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# Fineo & Tantalo
## A complex systems-oriented cognitive approach in the treatment of patients with eating disorders: Part two – Practice*

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***Summary***

*Eating disorders comprise one of the most complex and problematic psychiatric disorders that exist. There is, however, a significant lack of empirically validated literature outlining definitive models that explain the aetiology, pathogenesis, psychopathology and treatment of this devastating disease cluster.*

*The purpose of this paper is to describe a complex systems-oriented cognitive approach addressing the psychopathology and treatment of eating disorders.*

*The authors studied patients with eating disorders over the course of many years at the University of Captain Medical School (Italy), Department of Psychiatry and report the results of this research in two separate articles.*

*The first article (Part One) described general aspects of eating disorders including epidemiology, aetiology, pathogenesis and psychopathology as observed in this population. Part Two will present a unique model of evaluation, treatment and therapeutic approaches for patients suffering from eating disorders.*

*The prevalence of pathological eating disorders is rapidly increasing in all developing countries. The increases may be explained in part to the impact cultural, social, economic and historical variables have on populations vulnerable to the disease. These and other variables such as parenting style were analysed and the results are discussed.*

*A complex systems-oriented cognitive model concerning the psychopathology of eating disorders was developed and will be discussed in detail. The model identifies, defines and explains the biological, behavioural, cognitive, emotional and relational components explaining the psychopathogenesis and structural framework resulting in*

*Key words*: eating disorders, bulimia, anorexia nervosa

## THE FINEO AND TANTALO THERAPUTIC PROTOCOLS

After describing our conceptualisation of the eating disorders' dynamics at the behavioural, emotional, cognitive and relational levels, we offer the Fineo and Tantalo protocols, which we elaborated on earlier. We developed these protocols at the begin-

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ning of the 1990s and have been systematically implementing them in our practice in the second part of the same decade. In October of 1999, the American Psychiatric Association [1] published the guidelines for the treatment of eating disorders, updating those previously suggested in 1993. We were pleased to see that these guidelines take into consideration the same aspects that are highlighted in our protocols.

As we have emphasised, bulimia nervosa and anorexia nervosa are characterised by some common and contrasting aspects. The common aspects are linked to the cognitive dysfunction relevant to the body schema and the fear of gaining weight. The contrasting aspects are those connected to the behavioural level. In the bulimic patients, the general behaviour is minimally altered. Social relationships are maintained. The behavioural mechanism at the base of the dysfunctional coping is attributable to compulsion and then to bingeing. In anorexia, however, the problem involves food intake, and the dysfunctional behavioural mechanism is the avoidance of the eating behaviour.

As far as the setting and the relation are concerned, there are substantial differences between the two categories of patients. In fact, the bulimic subject's relational pattern involves the tendency to please the reference figure, while in the anorexic there is an active avoidance of the relations experienced as "controlling." This is extremely important for treatment purposes.

## SETTING, THERAPUTIC RELATIONSHIP, AND COMPLIANCE

### Fineo

Some of the clinical situations of bulimic patients may require a period of hospitalisation and may be summarised as follows [2]:

- The disordered eating behaviour and self-induced vomiting are so serious that they require check-ups and intensive medical care.
- The lack of order in eating is very serious and closely linked to the patient's daily events to suggest the opportunity of a radical change in their life style for a sufficient lapse of time.
- There are severe disorders resulting from the abuse of alcohol, psychoactive drugs or opiates.
- There is also severe psychopathology, such as a mood disorder with risk of suicide, a state of very marked anxiety, or psychosis.
- The family situation affects the patient and the treatment in such a negative way as to suggest a separation of the patient from his environment.
- When none of the above conditions is present, it is possible to implement ambulatory treatment.
- Considering the characteristics of the bulimic patient's family, usually the first contact is made by the relatives, who often accompany the patient to the initial session.
- Often the patient seems "resigned" to the treatment, and the relatives are ambivalent. On one hand, they minimise the patient's problem; on the other, they may attempt to evoke feelings of guilt.

  With reference to compliance, an apparent positive disposition towards the thera-

peutic work is observed initially; this at first gratifies the therapist, who assumes a pattern of acceptance and complicity. The initial resistance begins when the therapeutic work commences. For example, a critical item is the introduction of a video camera and the planning of video-monitoring sessions [3].

In such cases, quite an idiosyncratic pattern of emotional turbulence and substantial refusal of the patient to collaborate in therapy is evidenced. However, this resistance is neither disclosed nor discussed. On the contrary, the patient tries in every possible way to charm the therapist, entangling him/her in a manner that distracts him/her and potentially derails him/her from the treatment plan.

A distinctive problem is the family, especially when the patient is a young individual, [4].

The real "breakers" of treatment are the relatives who will withdraw the patient from therapy if they experience the therapist as an antagonist. They will attempt to collide with the therapist as an authoritative member of their clan who must consequently behave properly. They only want the therapist to solve a little problem they have, without changing the rules of the game. The risk of a sudden dropout is therefore extremely high with bulimic patients and their families. The patient and relatives may never openly disclose their hostility, but they will suddenly terminate the contacts. Therefore the therapist must be extremely careful when introducing the new elements in the therapeutic process.

A basic goal of treatment is to establish a valid and deep emotional relationship with the patient, and to carefully avoid his/her attempts to distract the therapist. The maintenance of psychotherapy as well as its meaning will essentially depend on the therapist's ability to acquire for the patient the role of "secure base". Perhaps the patient never experienced such a relationship in his attachment relation, which, vice versa, will be experienced as an element causing isolation and lack of confidence. Only by perceiving the therapist as a secure base, will the patient be able to overcome the unavoidable and sometimes auspicious emotional turbulence may surface during the tactical and the strategic phase of treatment, where relatives are likely to interfere with the process. Relatives must always be included in the therapeutic program, although definite rules must be set in order to minimise interference.

However, an important factor must be considered. The patient's recovery will imply a deep restructuring of the family system, which must then be accepted to promote change. In our experience, and consistent with what has already been stated, a strictly individual therapeutic intervention with the bulimic patient who resides in a family network of the kind described will have high risks of failure.

The last aspect to be discussed within this topic is that which is concerned with the physical conditions of the setting. As previously mentioned, hospitalisation is often necessary. In this case, it is indispensable that the team that accepts the patient is the same that will later conduct the treatment. In our Unit, we created a Cognitive and Rehabilitation Therapy Program, which is composed of cognitive psychotherapists who are trained by psychiatrists, as well as psychosocial rehabilitation technicians, who also trained to conduct cognitive interventions.

## Tantalo

In the treatment of anorexia, the need to initiate therapy under hospitalisation is quite frequent, due to the medical complications that accompany the disorder. With reference to the crucial aspect of construction and development of the therapeutic relationship, it is different with anorexic patients than with bulimic patients. In fact, with bulimia, an apparent receptivity to the treatment is recorded at the beginning of therapy, and the onset, still in elusive terms, of resistance is observed in the second stage of the treatment.

On the contrary, with anorexic patients the process is the opposite: meaning that it is very difficult to establish the therapeutic relationship but, once the alliance has been established, the anorexic patient will carry out his/her therapeutic work with much effort and discipline. The problem is to obtain the compliance in treatment early in the process. In the very early stages of the therapeutic relationship, it is necessary to activate relational patterns based on negotiation and activation of relational processes founded upon collaboration.

Our treatment proposal is conceptualised as follows.

*– You will not be "forced" to do anything that you do not feel comfortable with. I am here to provide care for you and to initiate an itinerary that is collaborative. I will offer some proposals that we can discuss and then mutually agree upon.*

It is of fundamental importance to become closely allied with the patient as soon as possible and, if necessary, to side with him/her and defend them, opposing the family's hypercritical, hostile and controlling attitudes. At our clinic, we usually speak quite frankly with parents and remind them that anorexia has a very high mortality rate and, if they want their relative to survive, they must allow us work unencumbered. This dramatisation, although not always to this intensity, is useful in acquiring more therapeutic power.

Usually, at the outset, parents ask for a forceful nutritional intervention such as the parenteral nutrition or the application of a nasal-gastric probe. These requests must usually be rejected, regardless of the situation. It must be stated that, nutritional therapy, like the rest of the therapeutic process, is not to be discussed with the family, but rather agreed upon by the patient. In this way, we possess more social influence in the patient's eyes, and this will predispose him/her to trust us and to co-operate more willingly.

## Multimodal and multidimensional assessment of the patient
## Fineo & Tantalo

Biological level [5, 6]

Nutritional aspects

Medical aspects
Psychophysiological level
Assessment of the electrodermal activity [7, 8]

Psychopathological level

Brief Psychiatric Rating Scale [9, 10]

Specific psychometric level

Eating Disorder Inventory [11]

Disability level

Disability Assessment Schedule [12]

Diagnostic level

Diagnostic and Statistical manual, 4th Edition (DSM-IV) [13]

### Assessment of the family functioning and emotional climate

Five Minute Speech Sample [14]
Relatives' Bonding Instrument [15]
Family Assessment Measure [16].

After the therapeutic collaboration is established and the assessment phase is completed, the therapeutic protocols may be introduced.

The articulation of the treatment program that we elaborated on may be divided into three stages: Phase I (behavioural level) of coping and problem solving aimed at a better management of symptoms; Phase II (emotional, cognitive and relational level), in which a progressive restoration of the emotional processes, as well as of the conviction systems and the relational patterns begins; Phase III (personal narrative level) where a progressive restructuration of the personal narrative history of the clinical experience in the context of the patient's personal life.

### Phase I (Behavioural Level)
### Coping & problem solving in the management of symptoms

This phase is characterised by the accomplishment of tactical resolution objectives such as:

A) Cessation of binge behaviour, self-induced vomiting and abuse of laxatives (Fineo)
   Cessation of fasting and of drastic food reduction and, whenever present, reduction of elimination behaviours (Tantalo)
B) Gradual introduction of a normal eating pattern (Fineo and Tantalo)
C) The beginning of a functional analysis of bingeing and self-induced vomiting (Fineo)
   Initiation of a functional analysis of fasting and the restriction of food intake (Tantalo)

Item A
**Fineo**

The accomplishment of the objectives included in this item may be conducted in the very early stage of the treatment, even by means of pharmacotherapy.

The prescription of 40 milligrams of fluoxetine per day allows the patient to be less propelled by the compulsion to binge and, in the less severe cases, to view this cardinal symptom of the pathology reduced to extinction [17]. It is obvious that this tactical success is to be wisely administered, repeating to the patient that this is a temporary result to be interpreted as a pause during which the therapeutic work must be intensified.

**Tantalo**

The first objective to pursue through an intervention of nutritional rehabilitation is to halt fast and restore acceptable physical conditions. The second target is to obtain an acceptable and agreed upon weight with the patient.

Nutritional rehabilitation

The emancipated state is not only a danger to the patient's life, but also an obstacle to the psychotherapeutic process itself. Since the patient is not able to eat properly, a proxy is required in order to take care of the patient's nutrition. Negotiation will allow us to stipulate a therapeutic contract that may be summarised as follows:

– *We both agree that you must not gain weight and remain slim. However, in this case fasting is a process by which you lost control and is a process, which tends to repeat itself, thus placing you at risk. Please remember that your objective is to remain slim and, if you die, you will never be able to achieve your goal!*

*The, next objective of ours will be the following:*

*To cease fasting, improve your physique, while still not gaining weight and remaining slim.*

*This is possible by means of a controlled nutritional rehabilitation program conducted with the supervision of the team in charge of the patient.*

*You promise to collaborate by eating the meals outlined by the nutritional program, which is the result of a negotiated and agreed planning. I, together with the team, promise:*

*To support you when you have to face the pain of eating and digesting.*

Item B

**Fineo**

The patient is asked to complete a form with the therapist involving the daily nourishment plan, which should include three main meals and two snacks per day. The patient will be asked to follow the schedule as continuously as possible, regardless of his/her current appetite. Therefore he/she will be required to eat what was agreed upon at the expected time with little or no compromise.

It is likely that the patient will show some resistance to eating three regular meals and two snacks because he/she believes this will make him/her gain weight. Then he/

she must be informed of the fact that this diet will decrease the possibility of binges as to allow for a calorie savings.

**Tantalo**

According to the clinical conditions, this phase of the treatment may take place autonomously; that is - the patient may conduct it under ambulatory treatment, in day hospital program, or an inpatient regimen. It is also possible to foresee an in-home Rehabilitation Therapist. In the last two instances, the meals are taken together with a therapist who does not hold a "controlling" role, but a supportive role of a helper for the difficulties the patient is forced to face from time to time.

In the first phase of the treatment, it is necessary to contract with the patient for a goal to be reached and sustained. Usually [18] a weight corresponding to a body mass of 19 kg may be accepted since it is viewed as capable of maintaining a condition of slimness, but also to allow a normal life and the development of treatment. In the first stage, the eating rehabilitation program plans for 1500 calories per day, divided into three meals and one snack. Later, the calories are increased to a level that the patient can accept. The patient's weight is measured by the therapist twice a week, but the patient is not informed in order to avoid anxiety, fears, and unproductive discussions. This practice is also a test for the therapeutic relationship and provides a verification of how much the patient "trusts" the therapist.

Item C

**Fineo**

We begin a functional analysis of the bingeing and self-induced vomiting patterns according to the previously explained conceptualisation and which is the fundamental premise for the self-control techniques based on biofeedback. The latter is a tactical instrument for the management of anxiety and therefore of coping with binges.

The functional analysis may be briefly summarised in the following terms. However, it must be pointed out that we explain the model to the patient in such a way that he/she may re-build from inside rather than accepting it as an axiomatic theory administered by the therapist. At this juncture, the theory must be based on real issues from the patient's experience and letting him/her re-formulate and write everything him/herself. The model we suggest to the patient may be summarised as follows:

Usually bingeing is preceded by moments characterised by negative emotions and is finalised to reduce this painful emotional condition. As previously explained, in the view of the dysfunctional behaviour, there is a wide variety of cognitive distortions which activate automatic processes of thought and the presence of systematic bias in the human information processing. Self-induced vomiting is in turn triggered by automatic thoughts relevant to the worry of gaining weight and losing control.

Through biofeedback, the patient may learn to cope more efficiently with the negative emotions, substituting the bingeing learned during his developmental history with self-control acquired during training. It is important to help the patient understand that his/her bingeing is a behaviour learned as an instrument to modulate emotions, albeit insufficient. Therefore, self-control may also be learned and may take the place of the dysfunctional pattern of the bingeing behaviour. Cognitive restructuring is aimed at

progressively correcting both the cognitive distortions and the information processing dysfunctional processes.

The conceptualisation suggested to the patient must be considered as a new theoretical conception. This new conceptualisation should not be accepted in a non-critical and passive way by the patient but, on the contrary, must be experienced and corroborated with actual data taken from the patient's daily life. At this juncture, the patient is assigned homework which consists of maintaining a diary that specifically details binges and is structured according to the well known modalities of the four columns form (events, emotions, cognitions, and behaviour) [19].

**Tantalo**

The behavioural intervention, aimed at allowing the patient to gradually start feeding himself in a positive way, is developed with the conceptualisation previously described and is explained and discussed together with the patient. The intervention rationale is that of being capable of reducing the neuro-vegetative enrolment connected with the nourishment phase; this is an arousal that produces a painful feeling of anxiety, a blockage of the gastric secretions and an end to the gastric peristalsis.

The patient is introduced to the biofeedback of the electrodermal activity and it may be very useful to perform in vivo experiments according to the following modalities. The patient is allowed to eat while the electrodermal activity is monitored. In this manner, the patient can observe on the monitor that, as soon as he/she consumes any food, a sudden and high increase in arousal occurs. At this point, he/she is invited to control the emotional activation and to consume a meal only after this target is achieved and the monitor indicates an all-clear signal. Through this manner of training, the untoward neurovegetative reactions that are at the base of the digestion blockage and precede the practice of self-induced vomiting are no longer conditioned.

**Phase II (Emotional, cognitive and relational level)**
**Emotions, Cognitions and Relationships**
**Fineo and Tantalo**

**A) Elicitation, Analysis and restructuring of the dysfunctional cognitive schemas.**
**B) Gradual modification of any negative attitude toward one's own body**
**C) Improvement in the ability to recognise and express one's own emotions**
**D) Improvement in the relational patterns within the family**
**E) Improvement in the social and relational competencies and implementation of social relationships**

A) Elicitation, analysis and restructuring of the dysfunctional cognitive schemas

A diary is utilised, which is part of the homework regime, in order to detect episodes where dysfunctional patterns are elicited. These patterns are gradually corrected, shifting from the most peripheral in the hierarchic organisation of meanings to the more central ones. This is achieved through the use of the technique of cognitive

restructuring.

B) Gradual modification of the negative attitude towards one's own body

In this second phase of the treatment the idiosyncratic, cognitive and emotional patterns begin to be analysed, with particular reference to those relevant to the body schema experienced as altered. The patient is encouraged to monitor, through written homework, the salient phases of his days, trying to highlight separately the events, emotions, thoughts and actions. In fact, significant literature data suggest that the failure in overcoming the disaffection toward his own body is one of the causes of the frequent relapses in bulimic patients. Therefore, it is important not to neglect this aspect of the treatment. In our experience, excellent results may be achieved using the video-monitoring and video-feedback technique associated with the monitoring and acoustic feedback of the electrodermal activity.

The patient is confronted with his body image, filmed from different angles and with different images He/she is encouraged to experience internally what the electrodermal parameter reveals through the external acoustic feedback mechanism. This indicates what process in his/her body is causing him/her anguish. Later, he/she is induced to try to observe his/her own image recorded in a relaxed state obtained with the aid of biofeedback over the course of the electrodermal activity.

C) Improvement in the ability to recognise and express one's own emotions

We work both on the material given by the patient from the homework performed and with the observations carried out by the therapist during the treatment process. The therapist systematically asks the patient to describe what he/she feels or he/she felt or believes he/she would think under different circumstances. The patient is progressively made more sensitive to his/her own emotional and interoceptive signals and is also trained, again with the help of video-monitoring and video-feedback, to express emotions also through role playing exercises. An important exercise to assign as homework involves self-observation in front of a mirror and of palpation of his own body.

The female patients affected with eating disorders demonstrate a very intense phobia and a constant avoidance toward her body image, which she avoids observing directly. For example, she may not look at herself in the mirror when taking a bath or showering. The rationale of this homework, which is discussed with the patient, is that it is not possible to re-build a positive body schema if no direct information is acquired. Due to avoidance, a strict vicious cycle is established and maintained, such as:

She feels fat, she never observes herself because she fears seeing herself as "fat," she continues to believe that she is fat.

D) Improvement in the relationship patterns within the family

It is necessary to contact relatives systematically, with the aim of developing a program articulated around the discussion of two main techniques:

1) The patient's symptom is somehow related to family relationships

2) Therefore, the elimination of the patient's symptoms requires the collaboration of the entire family unit.

The discussion of these topics may be initiated from the results obtained from the

Family Assessment Measure (FAM) that underlines remarkable alterations in different scales with regard to the bulimic patients' families.

Since the family members will have completed their questionnaires separately, without too much mystification, given the number of items and their location, data will emerge from the FAM scales that may surprise the family members themselves and about which initial discussion will be triggered. The following step may be that of trying to modify certain negative attitudes of a relative depicted in some of the patient's homework; for example, the tormenting advice not to overeat, the control of the patient to make sure he/she does not vomit, etc.

**Fineo**

In such a case, the therapist would send that particular relative "on leave," telling him/her that his/her efforts are praiseworthy and positive, but that he/she may assume a more passive role for a while; now that the therapist is the one in charge of helping the patient recover. These moves may be successful to the extent to which the therapist has been adopted by the bulimic's family and introduced in its network.

Also relatives must be involved in the re-planning of the daily activities of free time management, so that they may fill the gap of time created by the patient's improvement.

If this phase is successful, the family progressively becomes less dysfunctional and this may be highlighted by a new administration of the FAM, the results of which may be the starting point for a discussion of the progress achieved and the changes made.

**Tantalo**

In the case of anorexic patients, the fundamental goal is to reduce the control coming of the parents, especially from the mother. Common strategies characteristic of mothers of anorexic patients are not enveloping and mystifying as in the case of the bulimic patient's families, however, on the contrary, an atmosphere of conflict is immediately established, while the family retreats to a defensive posture. In such cases, it is necessary to thwart the challenging attitude and to blunt the aggressiveness by gradually inducing a collaborative attitude. To obtain this, we must put aside any critical and hostile attitude towards the relatives and explain to them that they are not responsible for anything. That is, they are not guilty but rather are victims, along with the patient, of mistakes made in good faith. Now it is time to look at the future and co-operate harmoniously in a task in which everyone; patient, family and therapist will be a winner.

E) Improvement in the social and relational competencies and implementation of social relationships

Social Skills Training is conducted and the patient is helped to promote his/her network. If necessary, this goal may be achieved with the physical presence of a rehabilitation therapist. Also the establishment of groups to meet and grow together

may be helpful.

### Phase III (Personal narrative level)
### Reconstruction of the historical dynamics of the disorder
### Fineo and Tantalo

After the patient has overcome Phase II of the treatment, a series of emotional, cognitive and relational patterns will be restored. Now it is necessary to activate the final phase of the treatment, aimed at challenging the patterns of systemic coherence with the self. This process is activated, within our protocols Fineo and Tantalo, according to two procedures previously described in the constructivist literature; the developmental history reconstruction [20] and the "self confrontation" [21].

#### The developmental history reconstruction

This is performed according to the guidelines and modalities described by Guidano [20]

#### *The "self confrontation"*

This method was developed in the constructivist field to promote a process of reconstruction of the self, starting from new experiences made during the tactical stages of the therapy.

Essentially, it consists of eliciting the patient's impressions and therefore his narrations of the present, but mainly of the past and the future.

Three stages are described in the "self confrontation":

- The *self-investigation* stage
- The *validation or invalidation* stage
- The stage where the self-investigation process is carried out again in the light of new information and experiences collected during the psychotherapeutic treatment.

In the specific case of protocols targeted to the treatment of eating disorders, the self-*investigation* is focused on the topics of personal value, the relationship with one's own body, and nutrition. The old story in which the patient described his problems as uniquely ascribable to himself, his poor personal value and his very bad physical shape is gradually replaced by a new story in which the negative role of experiences made in childhood and mainly in adolescence is enhanced. For the future, a new narrative plot is promoted around a new narrative may be constructed. This is a story in which the patient will be able to accept him/herself and to be loved independently from the response while in front of the mirror or on the scale. It essentially consists of encouraging the patient to re-build his/her developmental history and allowing him/her to place in a historical dimension his/her idiosyncratic modalities; He/she is encouraged to experience him/herself and his/her reality, linking his/her recent past as a bulimic to the remote past of his/her life in the family in order to project him/herself into a new ontological dimension to be developed in a future full of new possible evolutional issues.

Finally, we wish to specify that the effort for this plan of treatment is quite high

but, if we consider the severity of the disorder and its problematic prognosis, the cost/benefit relationship is still quite satisfactory.

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