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Małgorzata Talarczyk

COMPLEMENTARY APPLICATION OF PSYCHOTHERAPY TO THE TREATMENT OF FEMALE PATIENTS WITH ANOREXIA NERVOSA AND REFLECTIONS ON RESEARCH, BASED ON THERAPEUTIC PRACTICE

Department of Child and Adolescent Psychiatry, Poznan University of Medical Sciences
"System" Specialist Psychological Office
and Outpatient Department of Eating Disorder Therapy in Poznań

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Summary

The author shares her experience which she has gathered in the course of her long-time therapeutic practice of treating female patients with anorexia nervosa. She refers to the differentiation made by Seligman between efficacy studies and effectiveness studies in psychotherapy. She also considers the possibility of conducting research in the context of a complementary and complex therapeutic process. The complementarity of psychotherapy consists in the application of the systemic approach and elements of the cognitive-behavioural approach at respective stages of the therapeutic process, as well as the application of individual and family psychotherapy. In the article, the author describes the psychotherapy of people with anorexia nervosa treated on an outpatient basis between 2003–2019. The therapy was conducted individually and on a family basis. In the last 16 years, this psychotherapy has been applied to 475 Polish female patients aged 11–25. In the course of her therapeutic and clinical practice, and based on her gathered experience, the author has developed a therapeutic treatment which gives broadly understood positive effects. As regards research in psychotherapy, the author poses the following questions: Could one conduct research in psychotherapy which integrates various forms and paradigms? If yes – how? How to isolate and include a non-specific factor (the therapist) in such research? How to determine extra-therapeutic factors influencing the cognitive and intellectual processes of a person (people, in the case of family therapy) who is undergoing therapy? Is it possible to include the therapeutic influences described above in the Integrated Qualification System?

Introduction

The treatment of people with anorexia nervosa raises questions concerning the efficacy or effectiveness of psychotherapy. Their conclusions can be drawn from research data. Evidence-based practice (EBP) — being an aspect of evidence-based medicine (EBM) — "postulates the use of specific therapeutic methods in specific clinical situations whose effectiveness has been supported by scientific evidence" [1, p.10]. Research conducted through the lens of EBP (as one of the variants determining

effectiveness) is geared towards assessing the effects of the quotidian and typical work of therapists [1-3]. Szymon Chrząstowski [4] described and analyzed the difficulty of conducting EBM research in psychotherapy, which is related to the difficulty of controlling variables influencing the psychotherapeutic process.

When we consider the non-specific factor (not related to psychotherapeutic methods) being the therapist, his/her traits, life experience, therapeutic experience and his/her method of work, as pointed out by Bryniarska et al., a relevant question to ask is: Is it possible to determine individual effectiveness factors in psychotherapy? [1, 5, 6]. Questions concerning, among others, practice, evaluation as well as further development of psychotherapy are also posed by Feliks Matusiak and Barbara Józefik, the authors of the article "Around psychotherapy, including the psychotherapy of children and adolescents: Questions, challenges, controversies".

I do not carry out quantitative research in the context of outpatient psychotherapy of individuals with anorexia nervosa, but in my publications, I describe methods of such psychotherapeutic work. Considering the effectiveness of psychotherapy, I refer to the distinction forwarded by Seligman in 1995 [after 1, 2] into efficacy studies and effectiveness studies in psychotherapy. Matusiak and Józefik discuss research on efficacy and effectiveness in psychotherapy: "efficacy studies — studies in controlled conditions such as randomized clinical trials with a control/comparative group. Effectiveness studies — naturalistic studies reflecting everyday practice without control groups" [1, p. 10]. In sharing my experience, I interchangeably use the terms 'psychotherapy' and 'treatment' because a disorder, such as anorexia nervosa, necessitates more extensive medical care. Treating patients with this diagnosis should simultaneously include psychotherapy and medical care, most of all, a psychiatrist or specialists in other fields, should the need arise. However, psychotherapeutic treatment should be supervised or, if possible, conducted in therapeutic teams. In outpatient psychotherapy, I utilize complementary forms of therapy: family therapy, individual psychotherapy, sometimes group therapy, work with one's body or monitoring one's body weight. In my therapeutic practice, I draw on the systemic approach, also relying on the cognitive-behavioural approach. According to Kurt Ludewig, "the systemic approach has phenomenologically placed psychotherapy in the social domain, all the more so because everything that takes places in psychotherapy is communication […]. Bearing in mind the fact that a person can be adequately understood only if one considers various types of systems that constitute him/her — biological, psychological and social — psychotherapy should be understood as complex reciprocal social interaction among also complex multi-system entities, namely human beings" [7, p. 87]. I do not carry out research in the context of outpatient psychotherapy for the following reasons:

1. In outpatient practice, I provide therapeutic services and thereby I do not combine them with conducting research. The latter, for example in the form of questionnaires, would entail a change of contact and relationship with patients and their families. This is so in particular when parents with

their daughter approach me for help in situations when her health is deteriorating and sometimes also her life is in jeopardy, and expect efficient/effective therapeutic assistance. The provision of therapeutic services is a chargeable form of help offered by the therapist, and doing research in private practice, in my opinion, could violate the relationship between the service-provider and service-recipient. Research in the context of private practice could be interpreted by patients as re-directing the vectors from the "provider" to "recipient" of services because it would be the patient, and in the case of anorexia nervosa also his/her family who would provide a service (for instance, fill in questionnaires) to the therapist.

2. The second reason involves doubts about research methodology as raised by Szymon Chrząstowski in the article "Evidence-based practice in psychotherapy — the pros and cons" [4]. According to him, EBP research relies on a simplified model of mental disorder mechanisms and changes occurring as a result of psychotherapy. EBP favours these approaches in which investigated phenomena can be relatively easily operationalized in the form of variables" [4, p. 53]. Brzeziński also points out low external validity of this research since in clinical practice, numerous uncontrollable factors can influence research results [4, 8]. Factors not related to the psychotherapeutic process operate there, in particular when the person undergoing psychotherapy functions in their home, school, or peer milieu. In my professional experience, I have observed multiple times the deterioration of the patient's mental state for unpredictable reasons, for example because of peer conflict, or I have observed its spectacular improvement because of better relations in her peer group, a very good grade at school or a high place in a contest. Also, not without significance is the second reservation made about EBP which is linked to the so-called neutrality of the therapist and his/her world view [4]. The therapist's world view can involve not only the choice of research methods or the interpretation of research results but also his/her therapeutic work. In particular, it can be activated in family therapy in the context of confronting divergent world views held by the patient and her parents, concerning, among others, the system of values, religion, or politics. Although the role of the therapist is not to "resolve" world view issues, it often happens in family therapy that the therapist is invited by the family to a coalition of outlook. Against this backdrop, supervision should assume great importance irrespective of how extensive and how many years of professional experience the therapist has got.
3. Another reason relates to my application of various forms of therapy (individual, family, occasionally group therapy) as well as my reliance on various approaches of systemic therapy, *inter alia*, transgenerational, strategic, structural, or narrative, depending on problems or difficulties in a given family. Apart from the systemic paradigm, I draw on selected aspects of the cognitive approach in individual therapy, as well as elements of the behavioural approach when establishing a contract, for example, about suspending the patient's physical activity until she achieves given

body weight. I hence treat therapy encompassing various forms and approaches as mutually reinforcing pieces of a puzzle which, at a given stage of the therapeutic process, necessitates suitably selected therapeutic proposals, thereby creating a complementary whole. It would thus be difficult to point out which form of therapy, which paradigm or which approach within a given paradigm is effective in treating people with a diagnosis of anorexia nervosa.

4. The next argument against conducting research on effectiveness in psychotherapy relates to the tenets of systemic therapy which take into account the multiplicity and variety of factors influencing a person's functioning, including multifactorial etiology and the course of difficulties, problems, or disorders. This is reflected in the words of Ludewig: "As a child of the late 20th century, systemic thinking allows us to see the complexity of human existence simultaneously, we do not have to reduce it to individual biological, psychological, or social aspects. Apart from the pragmatic effectiveness of this way of thinking, it is right here that the greatest benefit to psychotherapy can be found" [7, p. 87].

Justification for undertaking outpatient treatment of patients with anorexia nervosa — the beginnings of my practice

Treating patients with a diagnosis of anorexia nervosa can be a challenge for therapists, which stems from the specificity and the course of the disorder, which is characterized by, *inter alia*, the patient's lack of motivation to undergo treatment, denial of the diagnosis, attempts at misleading the therapist and family regarding meal consumption and physical activity, as well as the patient's "fight" to maintain the symptoms and her fear of change. Such behavior of the person with anorexia nervosa impedes or prevents (in particular in the initial stage of treatment) the formation of a therapeutic alliance. A certain difficulty for the therapist can also be posed by his/her sense of responsibility, or over-responsibility for the effects of therapy in the case of a life-threatening disorder, which is even stronger since outpatient therapy is conducted single-handedly, which on multiple occasions forces the therapist to make important decisions for the patient and her family. That therapists fear treating people with anorexia nervosa I often hear while running workshops for therapists. Over 20 years ago I undertook single-handed outpatient treatment of individuals diagnosed with anorexia nervosa, having previously gained twelve-year clinical and therapeutic experience with patients hospitalized at the Department of Child and Adolescent Psychiatry, at the Poznan University of Medical Sciences. By clinical and therapeutic experience, I understand not so much trust in and attachment to one's frequently applied strategies or a belief in one's objectivity and knowledge of the subject matter [9], as everyday diagnostic and therapeutic work which is the basis for posing questions and hypotheses, and looking for new solutions and therapeutic proposals. In the department, apart from research on, for instance, the aspiration level and self-assessment of patients with anorexia nervosa, I also conducted individual psychotherapy or, on a team basis, family and group therapy, as well as I was also an author and

a co-author of new therapeutic proposals [10-12]. Between 1992-1996 I carried out studies on a group of 50 patients with a diagnosis of anorexia nervosa hospitalized at the department and compared their results with the results of the control group. The studies concerned the level of intellectual functioning (WISC-R and WAIS (PL) tests) and patients' emotional sphere (Sentence Completion Test, Thematic Apperception Test) as well as self-acceptance (Self-acceptance Scale SQ). The results of the conducted studies on intellectual development, achievement needs, and self-acceptance level of patients with anorexia nervosa were useful in my therapeutic work.

The aim of this article, where I signal difficulties related to treating patients with anorexia nervosa, is not to discourage young therapists from providing therapy to such patients. On the contrary, like in my other publications and classes with trainee therapists, I share here my knowledge and experience while paying attention to the specificity of working with this group of patients and their families. Not only does this specificity consist in the above-mentioned lack of motivation on the part of patients to undergo treatment and the related difficulty to form a therapeutic relationship but it also involves the need to provide family therapy as well as to monitor and/or treat the patient's somatic state. In turn, the patient's lack of motivation, in particular in the initial stage of treatment, constitutes a significant obstacle to take into account her preferences as one of the tenets of EBP. Such a patient's attitude forces the therapist to rely on the paternalistic model of relationship with her whilst forming a therapeutic alliance with her parents. As the therapeutic process proceeds along with her increased criticism and the gradually subsiding body image disorder, the relation with the patient also changes. It is the formation of such a diverse relationship that can pose difficulties to novice therapists.

The group of patients with anorexia nervosa treated on an outpatient basis

In this article, I share my experiences and reflections stemming from my therapeutic work with patients diagnosed with anorexia nervosa and their families between 2003 and 2019. During this period, I provided outpatient individual and family psychotherapy to 475 female patients. I do not distinguish restrictive anorexia and bulimic anorexia in this group. Below are the numbers of patients treated by me.

Year 2003	11 patients
Year 2004	10 patients
Year 2005	15 patients
Year 2006	15 patients
Year 2007	27 patients
Year 2008	37 patients
Year 2009	24 patients
Year 2010	38 patients

Year 2011	25 patients
Year 2012	25 patients
Year 2013	24 patients
Year 2014	26 patients
Year 2015	39 patients
Year 2016	46 patients
Year 2017	37 patients
Year 2018	36 patients
Year 2019	40 patients

It is difficult to regard the increase in the number of patients as an increase in the incidence rate because the above statistics present exclusively cases where patients sought help at my consulting room. I adopt a hypothesis that the rise in the number of patients approaching me for assistance could have been the result of my previous patients frequently recommending my services. During the first appointment, I ask each patient and her family how they got to my consulting room. Based on the parents' answers, it transpires that approx. 60% received my contact details on someone's recommendation and 40% found them in an Internet search. I also ask why the patients' parents chose my services described on the website, given the plurality of different online offers of treating eating disorders. According to them, their decision was determined by my experience, qualifications and publications.

The age of all the 475 patients ranged from 11-25 years, including 70% of the patients aged 13-18. The duration of therapy depended on the patient's mental state, her underweight, therapeutic needs, and my cooperation with her and her family. On average, it lasted a year with family and individual therapies combined. Because the group undergoing psychotherapy was not homogenous in terms of age (age groups: 11-13, 14-18 or 19-25), their emotional and developmental needs were different. Therapy was tailored to the patients' ages as well as phases in the family life cycle, which was different depending on the number of children in their families and their ages. For example, if a patient was an only child, her developmental age usually correlated with the phase in the family life cycle, for instance, the school-age child, adolescent child, or the empty-nest phase. However, if a patient had siblings, my therapeutic work with the family took into account the family life cycle, depending on her birth order. If she was the oldest child, one could adopt a hypothesis that it was the first time that the parents had experienced the child's separation and individuation processes. If she was the youngest, the parents could have been experiencing emotions, including fears, of the upcoming empty-nest phase [14]. At the time of concluding a contract and in the process of conducting therapy, both these factors, that is the patient's age and the phase in the family life cycle, were taken into consideration.

The criterion of patient recovery was considered in two areas: the first area — the diagnostic criteria of anorexia nervosa; the second area — the patient's functioning in and outside the family as well as

changes in family relationships. Recovery in the context of the diagnostic criteria involved two stages: firstly, an improved somatic state, that is, *inter alia*, reaching the expected body weight; and secondly, regression of the body image disorder, a return to consuming meals without avoiding those regarded by the patient as fattening during the disease as well as the abandonment of excessive physical activity and other compensatory activities aiming at bodyweight reduction [15]. In turn, family functioning and the patient's functioning in the family and her peer milieu were analyzed for each patient and her family on an individual basis. Particular consideration was given to her age, developmental and emotional needs as well as her family's structure, functioning and expectations to which approaches (structural, strategic, transgenerational or narrative) from the systemic paradigm were tailored [16].

What helps to treat patients diagnosed with anorexia nervosa

Diagnostic session

Having the experience of working with 475 patients and their families, I observe how the first diagnostic session motivates them to undergo therapy. During this session, if there are grounds for that, diagnosis is delivered in accordance with ICD-10 and DSM-5 [17, 18] or the patient is referred to a psychiatrist for diagnosis. During individual or family psychotherapy, the patients and their parents often talked about how important it had been to them to hear the diagnosis even if both of them hadn't wanted to hear it. For the parents, a diagnosis of anorexia nervosa had often confirmed their earlier assumptions, and hearing it from a specialist had been a motivation to treat the daughter and a factor which had gradually been weakening the patient's denial of the disorder. In turn, as the therapeutic process unfolded, the patients who had usually rejected the diagnosis admitted that hearing it had been a turning point whereby the problem had been identified by being named. Nevertheless, I often hear from the psychotherapists I train that delivering a diagnosis of anorexia nervosa, apart from a substantive difficulty, constitutes an ethical dilemma. By an "ethical dilemma", they mean that arriving at a diagnosis can have a negative influence on establishing a therapeutic relationship. However, when in workshop activities therapists take on the role of patient and her parents, almost all of them — while sharing their experiences of the "role-play" — discern and feel the need to know the diagnosis. This is so because diagnosis does not involve treating the disease but the person, the subject whose somatic and psychological sphere do not function properly as a consequence of the disorder and can threaten her life. Moreover, arriving at a diagnosis mobilizes and motivates parents to enter into cooperation with the therapist.

The significance of family therapy

Based on my thirty years of therapeutic experience, I find family therapy indispensable in the treatment of anorexia nervosa and see a few motivations for it. Firstly, as mentioned above, in the case of a patient whose disorder is health- and life-threatening, and who does not demonstrate motivation to

undergo treatment, family therapy enables her to start the process of therapy during which her attitude to the disorder and therefore to the treatment changes, which makes it possible to establish a therapeutic alliance. Secondly, family therapy is recommended in the context of the multifactorial origin of anorexia nervosa, that is, biological, personality-related, familial and socio-cultural factors. The third reason relates to the organizational and emotional involvement of the entire family, including the siblings, during the disorder. The fourth reason involves the age of developing anorexia nervosa — adolescence, which is the phase of family life when important developmental changes take place such as individuation and separation, normative teenage rebellion as well as the upcoming empty-nest phase. Given the familial specificity of patients with anorexia nervosa related to, inter alia, erased internal boundaries, rigid external boundaries, a tendency to avoid conflicts and excessive control, patient recovery and age-appropriate functioning would be difficult or impossible without family therapy. The fifth reason stems from the desire to prevent a situation where it is the patient alone that is burdened with the treatment and its effects if the familial system, being one of the most important systems in which the adolescent lives and on which her functioning depends [14, 16].

Loss of body weight — one of the axial symptoms of the disorder

In treating patients with anorexia nervosa, it is necessary to monitor their body weight and somatic states. The therapeutic process cannot overlook the axial symptoms of the disorder being body weight loss. Monitoring the patient's somatic state extends beyond psychotherapeutic intervention, and, depending on the needs, should be given over to a specialist — a psychiatrist, pediatrician, general practitioner, gynecologist, endocrinologist, or a cardiologist. In turn, monitoring the patient's body weight whose loss is one of the axial symptoms of anorexia can be done in different ways, for instance by one medical expert or by a therapist in the course of therapy. Unprofessional and unethical is considered a situation where during psychotherapy the patient's body weight is constant, that is, it does not increase or, what is worse, it decreases, which unfortunately does sometimes happen. This can be more dangerous and life-threatening than lack of therapy because during therapy, the parents' vigilance is dulled and they believe that if the sick daughter is receiving treatment, her state of health is the object of interest and therapy. This situation can be compared to the one where parents with their daughter who has broken a leg come to an orthopaedist or a surgeon, and the doctor talks to the patient for several months about her peer relations, school, dance, sports or gymnastic experiences, and neither does he/she attend to the fracture which necessitates quick intervention nor does he/she refer the patient to a specialist. In my publications and workshops, I have pointed out the need to take into account body weight, being one of the diagnostic criteria of the disorder and therefore a recovery criterion. Nevertheless, I continue to come across situations where a patient has been attending individual therapy for several months and her too low body weight has not increased or it

has even decreased. It is hence difficult to consider such intervention therapeutic, irrespective of the applied therapeutic paradigm.

Integrating individual and family therapy

L. Feldman, a child, adolescent and family therapist, in his publication "Integrating individual and family therapy" describing a multilevel integrative model of psychotherapy, points out positive outcomes of integrating both forms of therapy [19]. He emphasizes the benefits of approaching diagnostic and therapeutic problems from the intrapsychic and interpersonal perspective while remarking that the complementarity of both processes enables the therapist to offer broader therapeutic services [19]. In deciding on this model of therapy with children and adolescents, including those with anorexia nervosa, I invoke two areas of therapeutic work: the therapeutic relationship and the constructionist concept of the dialogical self.

Three elements comprise a therapeutic relationship: (1) a working alliance aiming at joint therapeutic work (on the part of a patient and their therapist), (2) transference and countertransference configuration, (3) the actual therapist-patient relationship, that is, a relationship which is independent of transference [20]. A more detailed discussion of the therapeutic relationship is beyond the scope of this article.

In the initial phase of working with patients diagnosed with anorexia nervosa, it is often difficult to build a therapeutic alliance, which is caused by the patient's denial of the diagnosis and, as a result, the need for treatment. One environment enabling the formation of a therapeutic relationship is a family therapy session.

The second area which I pay attention to in integrating individual and family therapy is the concept of the dialogical self, which distinguishes aspects such as: voices, words, and actions, positioning, sequentiality and inner voices of the therapist. By focusing on inner voices of the therapist, Józefik et al. point out their four levels. The first level involves "the therapist's conversations with the family, the second is the therapist's inner conversation, the third level relates to a conversation among family members themselves, and the fourth denotes conversations of family members set in a broader context (this can be their family of origin including deceased family members)" [21 p. 862]. One can hence assume that the family therapist hears, observes, and experiences on four different levels of dialogue, in turn the individual therapist on the first two ones.

Considering the psychotherapeutic process from the perspective of the multilevel integrative model in the context of a therapeutic relationship and the dialogue levels offers the therapist more opportunities to undertake therapeutic work concerning intrapsychic and interpersonal processes, in particular in patients without inner motivation to undergo therapy. I have discussed and attempted to justify issues related to the integration of individual and family therapy by one therapist in a separate publication [22]. In the case of

individual and family therapy of patients with anorexia nervosa provided by different therapists, patients can experience a conflict of loyalty to both the therapist and their parents. It happens in practice that one of the therapists aims to identify the source of the patient's behaviour and hence, for example, attempts to find those responsible for the disease whereas the other therapist struggles to reduce the parents' sense of blame for the disease and to improve the relationship. Another loyalty dilemma for patients and their parents tends to be issues concerning low body weight when, for example, one of the therapists focuses on this symptom whereas, for the other, weight and distorted body image are not issues in need of therapeutic intervention. In such a case, the patients will be more loyal to the therapist who does not concentrate on this symptom, in turn the parents will more readily take to the idea of also working on body weight.

Issues of body weight are also related to other loyalty problems concerning discrepancies in the proposed target weight for patients in the developmental age, established by different therapists according to a growth chart. In this case, the patients will be more loyal to the therapist recommending the lower weight, which can be disapproved of by their parents. This begs the questions whether and what inner, loyalty or interpersonal conflicts can be experienced by patients and their parents as a consequence of having different therapists with their not always congruent interpretations or therapeutic interventions, and how these conflicts can influence the therapeutic process. From my experience of providing both forms of therapy by different therapists, it transpires that there can happen misunderstandings pertaining to different therapeutic interpretations, arrangements, or interventions, including loyalty problems enmeshing the patient and her family. That is why I discern more benefits than dangers in integrating both forms of therapy with patients diagnosed with anorexia nervosa. Since I introduced the transgenerational model of work on disturbed body image to individual therapy, the integration of both forms of therapy has been proven particularly beneficial. It should also be pointed out that this integration necessitates particular mindfulness and sensitivity on the part of the therapist, and entails an additional burden related to, *inter alia*, non-disclosure of topics discussed in individual therapy during family sessions. On the other hand, these sessions provide an opportunity to bring up topics from individual sessions by drawing on circular questions. Circular questioning allows the therapist to discuss, in a safe manner without breaching the secrecy of individual sessions, topics important to the patient which she does not want to raise during family sessions. Posing a circular question to each parent during a family session, such as "What changes does your daughter expect in the relationship with you as the mother or father?", allows the parents to see the relationships from the daughter's vantage point, without the patient verbalizing these relations. This enables the therapist to draw on the four levels of the dialogical self in each form of the conducted therapy.

Individual and family therapy sessions are usually arranged alternately, that is, family sessions take place once a month, and individual sessions once a month so that the therapist meets the patient every two weeks.

The myth of willpower and control in the therapeutic narrative

For almost thirty years of my therapeutic work with patients with anorexia nervosa I have been trying to identify areas which are conducive to sustaining the disorder symptoms by the patient and which impede treatment; areas, apart from ego-syntonicity, which are so subjectively important and satisfactory that the patient cannot or does not want to eradicate them. One of such areas is satisfaction which the patient derives from the subjective confidence in her own will power and control. Years ago, when I introduced this topic to individual therapy, I observed patients conversationally taking it up and reflecting on it with mindfulness and consideration. Discussing this issue goes far beyond the scope of the present article, however, in a nutshell, the topic of "free and strong will" and control as an illusion constitutes one of the turning points in individual therapy. At an appropriate stage of treatment, patients with a diagnosis of anorexia nervosa thoughtfully state in surprise that in fact, they are deprived of their own willpower and control, and remain subordinated to the "will and control" of the symptoms. My discussion of therapeutic work focused on "free and strong will and control" has been published elsewhere [23].

Disturbed body image—a therapy proposal

Disturbed body image according to ICD-10 is one of the diagnostic criteria but it is also one of the symptoms which impedes treatment, and usually subsides the latest. A distorted body image, similarly to the issue of willpower mentioned above, induced and still induces me to look for methods of therapeutic work which would help the patient "free herself" from her distorted body image perception. My conversations with patients have inspired me to put forward the following two hypotheses: the first one concerning the transfer of emotions (most often anger) experienced by the patient in various domains, for example, frustration with school grades or family or/and peer relationships, to her body image perception. In individual therapy, I work on the identification of negative emotions, their acceptance, and next on their communication, whereas in family therapy, I focus on the patient's and other family members' permission for and acceptance of emotional expressions.

The other method of individual therapy targeting the disturbed body image has also been developed in the course of hundreds of my conversations with patients. I call this method transgenerational whereby, together with the patient, I examine similarities between her build and the build of other members of her family of origin. Discerning similarities to the mother, grandmother, great-grandmother or aunt etc., also by watching their photographs from their youth, allows the patient to identify with them and to give up her struggles to achieve "the ideal body" promoted by fashion models or celebrities in the media. This form of work has been described elsewhere [24].

Questions about the effectiveness criteria of psychotherapy in treatment provision to patients with anorexia nervosa

A relevant question in this context is: What does effective psychotherapy of patients with anorexia nervosa consist in? Is recovery from the symptoms which constitute the diagnostic criteria of the disorder a sufficient condition of effective therapy? It can be said that an indispensable condition for the patient's somatic recuperation is her recovery from symptoms such as: a) body weight loss — that is, achieving appropriate body weight, b) abandonment of avoiding and eliminating food, c) restoration of adequate body image, d) recovery from endocrine disorders and gonadal-pituitary axis disfunctions. However, this indispensable condition is not always sufficient. Therapy, both individual and family, entails changes in one's functioning in various areas which most often involve: self-assessment and self-esteem, a decrease of one's aspiration level (accommodating aspirations to one's intellectual abilities), changed family relationships in terms of setting internal boundaries and relaxing external boundaries, improved communication whereby parents let their daughter express her views which are often different from those held by them, emotional permission for separation and individuation, the patient's release from family delegations as well as more satisfactory peer relations. Nevertheless, parents' frequent expectation for the daughter to become the same person she was before the disease cannot be fulfilled. There are a few reasons for that. Firstly, the patient's age changes, that is, she developed the disease and finished therapy, being at different ages. Secondly, the experience of having anorexia nervosa and of participating in psychotherapy changes her emotional and cognitive processes. Thirdly, family therapy effects changes in relationships and communication. According to one patient: "After therapy, nothing is the same".

I do not have any information concerning the durability of the effects of my therapeutic interventions. A few years after therapy completion, several patients approached me again for help with, for example, marital or parenting problems, but not with anorexia nervosa.

In the psychotherapeutic literature on anorexia nervosa, irrespective of the therapeutic paradigm, two stages of therapy merit attention. The first one deals with an improved somatic state, including an increase in body weight. The second refers to changes in one's emotional functioning. In the literature, there are accounts of therapeutic work with this group of patients in different therapeutic paradigms: psychoanalytic, psychodynamic, cognitive, systemic, psychoeducational, or behavioural (at the time of concluding a contract). There is also a recommendation for implementing the integrative model (for example, combining psychodynamic and cognitive-behavioural therapy). Each of the paradigms in line with the theoretical assumptions can focus on different aspects of the disorder [25-28]. Recommending any particular therapeutic method or school should be supported by research results. Hence, there appear dilemmas pertaining to efficacy and effectiveness studies in psychotherapy, as well as the question — to what extent the standards of randomized controlled trials (RCT) found in medicine can be applied to research in psychotherapy? [1]. Because of the multifactorial etiology of anorexia nervosa, I draw on the

systemic paradigm, using various approaches (schools) and taking into account the patient's age, needs, and the phase of her family life cycle. When concluding a contract concerning an increase in body weight, I use the behavioural approach. However, in my work on a disturbed body image, I rely on the cognitive approach. This way of psychotherapeutic work can be described as integrative. In turn, by referring to the multilevel integrative model forwarded by Feldman, I integrate individual and family therapy. I thereby described my work with patients and their families as complementary.

Recapitulation

To sum up, I return to the question concerning the possibility of planning and carrying out efficacy studies on or determining the effectiveness of complex and complementary psychotherapy of patients with anorexia nervosa. Is it possible and, if so, how to conduct research in the context of psychotherapy integrating various forms (family, individual, and group therapy), various paradigms (systemic, cognitive, behavioural) and, in the systemic paradigm, psychotherapy which integrates various approaches (structural, strategic, transgenerational, narrative, mentalization-based)? How to isolate and take into account the non-specific factor, that is, the therapist, in such research? How to determine extra-therapeutic factors influencing the cognitive and emotional processes of the patient (individuals — in family therapy)? Is it possible to consider the therapeutic impacts described above in the Integrated Qualifications System (IQS), which enables one to easily compare the skill levels of specialists educated in different countries of the European Union? Matusiak and Józefik describe the scientific-research context of psychotherapy, pointing out that psychotherapy is located between medical sciences and the humanities [1]. Barbara Józefik also poses the question: "Does psychotherapy need to be science?" [29, p. 743]. Chrząstowski answers that "it is not necessary for psychotherapy to be science but psychotherapists cannot undermine science either because otherwise psychotherapy will cease to develop, becoming a backwater of ideas excluded from science" [4, p. 56]. In response to Józefik's question, it can be said that "it depends on the kind of science through whose lens psychotherapy is viewed". In the context of medical sciences, it is evidence-based research (EBM) that decides about the scientific character of psychotherapy. Will it be the same in the context of the humanities? There appear other questions too: Will the humanities find their application and earn recognition in medical sciences, and, if so, to what extent? If considering psychotherapy science is conditioned on the requirement to study its efficacy, doubts are raised about the comprehensive (with a multifactorial effect) therapeutic application of psychotherapy. Professor Andrzej Friszke points out that Polish intelligentsia, cultural creators and scholars are in danger of escape to the international score databases, closed circulations of "science for science's sake" [lack of reference — the quotation has been taken from a lecture available online]. As he states, "pointosis" leads to confining humanists in detached narrow groups where our publications are read by several or at most several dozen people" [30]. Even though Fiszke's words do not refer to psychotherapy, they lead to reflection whether the humanist's concern

with “pointosis” endangering the humanities can also pose a threat to psychotherapists and psychotherapy? Can one’s concern with points for publications, and hence also for research results, run the risk of reducing psychotherapy to spot measurements?

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Email address: talarczyk@psycholog-ambulatorium.pl