

THE HELP OF BEHAVIORAL COGNITIVE THERAPY

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Abstract: This study provides an overview of the concepts of eating behavior disorder theory, about the intervention used, the effects on eating behavior disorders and factors associated with unhealthy eating behaviors. It aims to capture important aspects that occur on the one hand in the behavior of people at risk of eating disorders and on the other hand to highlight the usefulness of therapeutic and training programs in this regard.

Keywords: *eating behavior disorder, diet, behavioral cognitive therapy.*

Theoretical frame

An eating disorder is a disease that manifests itself through a variety of unhealthy eating and weight control habits that become obsessive, compulsive, and/or impulsive in nature.

Eating disorders are not new. The ancient Greeks were known for their purification, as the Romans during Caesar's time (700 BC) were well known for invoking spirits that were built in order to make it easier to overcome greed and then vomit for to continue eating and drinking.

Bulimia nervosa, as we know it today, was officially added only as a mental illness to the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (revised) in 1987.

Anorexia seems to have its roots back in the thirteenth century, when certain religious women were in fact canonized as saints for their fasting practices.

According to the Diagnostic Manual and Statistical Classification of Mental Disorders (DSM V), eating disorders are described by persistent impairment of eating or eating habits that result in improper consumption or inappropriate food intake, and which harm the physical health or psychosocial functioning of the individual.

Diagnostic criteria are also established for disorders such as pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa and compulsive eating disorder.

Pica, in fact, a basic feature is the consumption of a substance or substances that are not edible, non-food, and do not have a nourishing value lasting at least one month.

The specific feature of rumination disorders is regurgitation of food after lunch several times for at least one month.

The main diagnostic criterion for the avoidant/restrictive food intake disorder is to avoid or limit food intake, which is manifested by failure to reach nutritional or energy needs through oral food intake.

In the case of anorexia nervosa, three essential elements are known: persistent limitation of caloric intake, intense fear of weight gain or obesity or persistent behavior to prevent weight gain and disorder in the perception of one's own weight or body shape.

In bulimia nervosa, the ingestion takes place in a short, for example, twice the amount of food that far exceeds the amount that most individuals would consume in the same time and under the same circumstances.

An episode of compulsive eating is characterized by the ingestion in a short period of time of two hours of an amount of food that far exceeds the amount that most individuals would consume over the same period of time and under the same circumstances.

The specified eating behavior disorder applies to clinical pictures in which the symptoms characteristic of a food-borne disorder that cause discomfort or clinically significant deficiency in the social, professional or other important areas of activity are predominant, but they do not meet the full diagnostic criteria for either of disorders belonging to the class of diagnostic behavior of food.

Treatments and methods of care

In the case of anorexia nervosa, there are two main factors contributing to facilitating treatment for this disease: clinically, the instigation of withdrawal of the protocol due to failure to stabilize the risk to the person and withdrawal of the patient due to its poor acceptance of treatment. So in this case it is useful to advise and recommend a multidisciplinary approach including medical, nutritional, social and psychological therapy. Psychotherapy is one of the approaches.

Parents are in difficulty and are burdened with the symptoms and behaviors of eating disorders. These feelings can be mitigated by group educational interventions (Cochrane 2008). Behavioral cognitive therapy considers that interpersonal factors such as emotional disturbances, perfectionism and self-esteem are factors that contribute to the maintenance of

the disorder and do not help to substantially improve this outcome. The choice and availability of food plays an essential role in understanding food behaviors.

People are no longer dependent on light and obsessive food when they are predominantly at our disposal. It is important to be aware of consumption behaviors. Traditional diversity is seen as a benefit for diet maintenance and global nutritional health (Toray & Cooley, 1997). However, there are also negative implications for the diversity of diets. For example, if people are given a wide variety of low calorie foods, they will eat more than they would normally (Kennedy, 2004). The same concept applies from a positive perspective, as the desire to eat a food decreases with consumption. However, when a wide variety of food options are presented, such as a canteen, the desire for positive stimulation to indulge in the rest of the food is not as important as the first element, but there is still contributes to the over-feeding of the individual (Nayga, 2000).

Over the past 15 years, research into eating disorders has found that cognitive behavioral therapy is very effective and plays an important role in this regard (Williamson, & Varnado, 1995).

Most previous theoretical research focused on behavioral predictions of behavioral cognitive theory.

These studies (eg WP Johnson, Jarrell, Chupurdia, & Williamson, 1994; Rosen, Leitenberg, Fondacaro, Gross and Willmuth, 1985; Williamson, Prather, Goreczny, Davis & McKenzie 1989) increased after eating large amounts of food or having consumed forbidden foods and declining after eating. Studies have also removed that overeating often occurs after discontinuation of the diet (Polivy & Herman, 1995) when there is a disposal variant to prevent weight gain (Duchmann, Williamson, & Stricker, 1989). Other studies show that adolescents in homecare center presents eatig disorders as a feature of their adaptatio difficulties (Breaz, Iovu, 2018).

Other cognitive studies have used various self-evaluation inventories to test hypotheses that people with eating disorders have maladaptive or irrational beliefs about diet and body shape and weight (McGlone & Ollendick, 1989). Destruction of healthy eating habits and pathological weight control strategies are the most obvious signs of an eating disorder.

Cognitive behavioral therapy for eating disorders highlights the change in both disturbed eating behavior and body-related knowledge and eating.

Cognitive distortions in eating behavior disorders

Awareness of threatening stimuli allows a person to avoid situations that cause anxiety and adversely affect him (Mathews, Richards, & Eysenck, 1989). People with eating disorders are afraid of weight gain and therefore stimulate fat-related processes as threatening (Fairburn et al., 1991). Such stimuli should capture attention more easily than stimuli that are emotionally neutral.

In conclusion, these studies have found that overweight weight and body shape seems to point to the relevant stimuli that can work to maintain concern for body shape or nutrition.

Cognitive behavioral theory predicts that information related to an individual's concerns will be more easily coded in memory and easier access to revocation. Because research has shown that stimuli need emotion as well as the relevance of content to their expression (Mogg & Marden, 1990), the authors also examined the effects of negative induction on the disposition of revocation. Study results suggest that fat word revocation is increased in people diagnosed with eating disorder and in people who are concerned about body size and shape (Baker et al., 1995).

Other memory results support the predictions of the cognitive behavioral theory of eating disorders. It is noted that people with eating disorders selectively recall fattening information and have difficulty remembering their information about being weak (Williamson, 1996).

Bruch (1962) is recognized as the first to describe the negative body image as a primary feature of eating disorders. A few years later, Slade and Russell (1973) investigated the accuracy of perception of estimating body size in patients with eating disorders. They have found that patients with food disorders have overestimated their body size compared to subjects in the control group.

How do people thinking about diet thinking about people who do not need diet?

The way the client thinks about the situation is the main factor that sabotages the diet and makes it difficult to withstand the trigger factor.

There are some very interesting differences between what a person who fails to keep up with the diet thinks, compared to those who have successfully followed their weight loss plan with the Beck Diet Solution program. Both are confronted with the same type of triggers. But the difference between those who are not successful and those who succeed is that they have certain characteristics and ways of thinking that can lead *to failure*.

Identifying Thoughts

Most of the time, customers are unaware of the thoughts they have before eating. They can sometimes take only one millisecond. The automatic thought can be simple: "I want to eat this."

Through this program the client learns how to identify these thoughts. Whenever they feel the desire to eat will learn to ask themselves the question: "What is going through my mind right now? What am I thinking? "

Thoughts that occur when the customer eats

It's amazing how creative our mind can be when we really want to do something that we do not need. The customer tends to think like this: "It's good to eat this because ... I'm stressed/I'm hungry/I do not care /I really

want/Everyone else eats/looks so good/I can't resist/I will start my diet again tomorrow/I am free to do this/no one is watchin /I have the right to celebrate etc. Often, the client is not aware of how faulty this kind of thinking is. The client is aware of and admits he would not be willing to eat if he wants to lose weight. But sabotaging thoughts can be quite convincing. Fortunately, there are powerful tools to counter these unhelpful thoughts.

Methodology

In this study was used an experimental design with control group and intervention program which in this case was the independent intergroup variable. The study aims to compare two groups. The experimental group participating in the intervention is tested before and after the intervention and the control group remains unchanged.

The results from the two groups are compared and analyzed to see if the experimental treatment produced any change.

Participants

This study was conducted on a sample of 24 rural and urban subjects aged 25-35 years, 6 males and 18 women forming 2 distinct groups. Of the total subjects, 12 formed the experimental group that was tested pre- and post-intervention. The 12 participants in the control group were tested once and did not benefit from the intervention.

Instruments

EDI-3 Food Behavior Disorder Inventory is an instrument of self-assessment of features or psychological constructs that have been shown to be clinically relevant for the development and maintenance of eating behavior disorders.

It includes 91 items, grouped into 4 scales. Each item contains 6 variants of answers: Always (I), Usually (O), Often (A), Sometimes (C), Rare and Never (N).

The EDI-3 inventory is built to support the clinical assessment of people with eating disorders, it provides standards for the following diagnostic categories DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, 4th addition: Restrictive nervous anorexia, anorexia nervosa type - compulsive eating/vomiting, bulimia nervosa, eating disorders without any other specification.

Therapy

This intervention is implemented over four weeks. It takes place at a frequency of two-session sessions per week, sessions lasting 2 hours/session.

It is a four weeks program that teaches the client a different psychological ability in each session to help him achieve his goals of losing weight.

Beck Diet Solution, is a different diet than other diet programs. From the beginning, this does not include a diet plan. It also does not specify what to eat the customer or even when to eat.

Instead, the Beck Diet Solution program teaches the client all the skills he needs in order to be able to stay on any nutritional diet choosing, to get rid of overweight and maintain the ideal weight in time. These abilities are based on the principles of cognitive therapy, which is one of the most common and powerful psychotherapies practiced around the world today. Demonstrated in hundreds of research studies to be effective in treating a variety of psychological issues, cognitive therapy focuses on helping the client change their thinking so that they can maintain lifelong change in their behavior.

Objectives of therapy

Participants will choose a nutritional diet and a reasonable exercise program; they will find out what happens in our minds when we are on diet, how we think about food, how we think when we want to eat our favorite food even if we're on the diet.

Participants will learn to plan and monitor in writing what they eat.

They will learn to adopt good and healthy eating habits so they can taste, texture and enjoy every meal.

They will resolve the diet and exercise issues by counseling.

There will be a transition to thinking: "This will be my meal and exercise program for the rest of my life."

Conclusions and discussions

The results obtained before the intervention and after the intervention were different, we can say that after the intervention the results of the disorders of eating behavior have improved considerably.

All the scores obtained were high, which means that before the intervention all participants reported concerns about the desire to lose weight and discontent with body weight. There were no significant differences in reducing the risk of food behavior disorders, ineffectiveness, interpersonal problems, emotional problems, exaggerated control, and general psychological unbalance between the pretest experiment group and the control group.

The high scores obtained by participants in all pre-intervention samples at the pretest stage showed their concerns about eating behavior disorder and body weight.

Most participants had very high scores on the scale of dissatisfaction with the body and at risk of eating behavior disorder.

For most participants in the intervention, the desire to be weak coincided with the restriction of feeding (not eating, starving), on the other hand the feeding brought with it the worry of not being able to keep up with a diet and fears of growing bigger to not get fat.

Often, the desire not to get fattened encouraged them to try a diet then another, and when they did not have the desired effect, they were self-criticized or socially deprived, it was not just the thought of trying another diet.

As early as the first session, they said they had a self-perceived self-esteem, and often feel ineffective, and with their weight gain they lost their self-esteem. Higher scores in the pre-intervention phase have demonstrated this. In addition to improving their results during this time, they have chosen a nutritional diet and a reasonable exercise program to plan and monitor in writing what they ate.

They have learned to adopt healthy and appropriate eating habits so that they can truly enjoy each meal.

They have in particular acquired a number of skills that helped them achieve both better test results and personal lives.

They have learned an important skill to plan food and calories in advance, to enjoy life not only through food, and not to feel that they are sacrificing for what they want in the long run.

On the one hand it can be said that due to the pressure not to lose control of life, they want to be more firm and consistent in the diet they will choose in the future.

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