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Theories and Treatment of Anorexia Nervosa

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THEORIES AND TREATMENT OF ANOREXIA NERVOSA

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THEORIES AND TREATMENT OF ANOREXIA NERVOSA
Table of Contents

Chapter                                                                 Page
1. Proposal
   Introduction .................................................. 1
   Statement of the problem ................................. 2
   Need for the study .......................................... 3
   Definitions of terms ...................................... 4
   Limitations of the study ................................... 5
2. Review of the relevant literature
   Criteria for the diagnosis of anorexia nervosa .......... 6
   Theories relating to the causes and onset of anorexia nervosa .. 9
   Characteristics attributed to the anorectic and the family .. 16
   Behavioral therapy in the treatment of anorexia nervosa ... 25
   Family therapy in the treatment of anorexia nervosa ....... 40
   Individual therapy in the treatment of anorexia nervosa ... 56
3. Summary and conclusions
   Summary of findings ........................................ 61
   Conclusions .................................................. 64
   Recommendations ............................................ 65
   References ................................................... 67
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Chapter 1

Introduction

The purpose of this paper is to examine the theories and treatment of anorexia nervosa. Once a rare disease, anorexia nervosa is now so common that it presents itself as a real problem in high schools and colleges (Bruch, 1978). A severe case of anorexia nervosa now appears approximately once in every 200 girls, aged 16 and over (Crisp, Palmer, & Kalucy, 1976). Physiological manifestations of anorexia nervosa can produce fatal results with mortality rates ranging from 10% to 23% (Van Buskirk, 1977). Anorexia nervosa typically surfaces in adolescent females and is manifest by self-induced starvation and severe emaciation. Males and older persons can also be affected by the illness (Ramsey, 1976).

Bruch (1978) talks about anorexia nervosa as a disease in epidemic proportions with no contagious agent; the spread of which must be attributed to psycho-sociological factors. It rarely affects poor people and has not been described in underdeveloped nations. A puzzling feature of anorexia nervosa is that it primarily affects young, healthy girls who have been raised in comfortable, even luxurious circumstances. The spread of anorexia nervosa may be attributed to society's enormous emphasis on slimness and woman's new capacity to experience fuller
freedom to use talents and abilities.

Whatever the reasons, anorexia nervosa is on the rise and has become more common (Bruch, 1978). One major point of agreement among those who study anorexia nervosa is that it is a "distinct illness with an outstanding feature: relentless pursuit of excessive thinness" (p. ix). Differentiating between anorexia nervosa and a weight loss stemming from other reasons must be established before any treatment is begun. Those young women who appear to lack interest in food and eating are usually intently preoccupied with food and its preparation. Anorexia, meaning lack of appetite, is somewhat a misnomer since food intake is curtailed but hunger is not. (Anorectics see their not eating as an exercise in discipline and self-denial and condemn their desires and needs as selfish.)

Statement of the Problem

The purpose of this paper is to explore the literature of the past ten years dealing with the theories and treatment of anorexia nervosa. Because of the rare incidence of anorexia nervosa in males, this paper will limit itself to female anorectics. The paper will be organized into six sections: 1) criteria for the diagnosis of anorexia nervosa, 2) theories relating to the causes and onset of anorexia nervosa, 3) characteristics attributed to the anorectic and the family, 4) behavioral therapy in the treatment of anorexia nervosa, 5) family therapy in the
treatment of anorexia nervosa, and 6) individual therapy in the treatment of anorexia nervosa.

Need for the Study

Because anorexia nervosa can be fatal and is on the rise, counselors, therapists, teachers, and other "helping" professionals need to be aware of the existence of the illness and how best to treat it. The majority of anorexia nervosa patients have been treated by medical personnel, but properly trained community mental health workers may intervene in treatment with a medical doctor on the consulting end because of the physiological aspects of the patient (Liebman, 1979). A systematic approach to anorexia nervosa treatment is transmissible to other workers in the field (Rosman, Minuchin, Liebman, & Baker, 1976).

There are two major areas of concern in treating anorexia nervosa patients (Van Buskirk, 1977). The first area is the need to restore the patient's body weight to a safe level in a relatively short amount of time. The second is "how effective the treatment is in maintaining a safe weight and insuring adequate adjustment over a long period of time" (p. 529). The effectiveness of treatment is evaluated by examining the social and psychological long term adjustments. The success of treatment is also contingent upon the length of time the patient has exhibited the symptoms. "When anorexia nervosa patients are treated within a year of the beginning of
the illness with an open systems approach in the context of their family, they can be cured in a short period of time" (Rosman, Minuchin, Baker, & Liebman, 1977, p. 348). It is therefore essential that "helping" professionals be aware of the many aspects of anorexia nervosa treatment and how they might involve themselves in treatment from the standpoint of direct intervention or referral.

Definitions of Terms

The DSM-II (1968) lists anorexia nervosa under special symptoms as a symptom under feeding disturbance. The symptom may not be the result of an organic illness or defect of other mental disorders.

Experts disagree on the specific characteristics of anorexia nervosa, however there are definite similarities among all involved. Rollins and Piazza (1978) in a review of the literature list nine widely-accepted characteristics of the illness:

1) severe weight loss resulting from not eating
2) fears of becoming fat
3) obsession with food and eating
4) high physical activity level
5) distorted body image
6) amenorrhoea
7) low incidence of male cases
8) resistance to growth and change
9) depression.
Limitations of the Study

The limitations of this study with regard to the counseling profession at this point have to do with the lack of awareness by counselors of the anorexia nervosa syndrome. This stems from the fact that here-to-fore anorexia nervosa has been seen as a medical problem to be dealt with by medical practitioners. With the advent of family therapy as a treatment of choice, the door is opening for more counselors to become actively involved in therapy for the anorectic and her family.
Chapter 2

Criteria for the Diagnosis of Anorexia Nervosa

Before beginning a review of the literature concerning anorexia nervosa, it is important to establish its meaning and use as a diagnostic term. Anorexia nervosa is a medical syndrome that occurs primarily in adolescent girls and is characterized by amenorrhoea (an abnormal suppression or non-occurrence of menstruation) and gross weight loss due to self-induced restriction of food intake (Hall, 1975). The anorectic has an unusual handling of food, a distorted attitude toward eating and body image, and exercises rituals of persistent overactivity (Halmi, Powers, & Cunningham, 1975). The voluntary refusal to eat is usually explained away by the patient saying she isn't hungry and is accompanied by a loss of 20% or more of the body weight without organic cause. Other primary psychiatric diagnoses, such as phobic states, depressive reactions, and psychoses, must be ruled out (Liebman, Minuchin, & Baker, 1974). Constipation, amenorrhoea, a lowered basal metabolism, reduced blood pressure and pulse rate, and dry scaly skin are all important clinical symptoms. The patient exhibits faulty perceptions of both their own food intake and the intake of others, unusual eating habits, and a considerable increase in body activity (Tolstrup, 1975). Whipple and Manning (1978) reiterate Bruch's description of anorexia...
nervosa as "the relentless pursuit of thinness" (p. 161). This illness traditionally has not had a good prognosis and the mortality rate has ranged from 5% to 20% of the treated population.

The diagnostic criteria is not uniform in the study and treatment of anorexia nervosa. In a study of 25 female patients aged 16 to 21 years in the Eastern District Hospital in Glasgow, Scotland, 20 of the 25 exhibited certain predominating factors: denial of illness, body schema disturbance, preoccupation with food, invariable weight loss, and amenorrhoea (Hamilton, 1975). Twenty-two patients in a study in Wellington, New Zealand, fulfilled the following criteria: onset before 25 years, amenorrhoea, weight loss of at least 25% of original body weight, a disturbed attitude toward food and weight gain, and no known preceding psychiatric illness (Hall, 1975).

Differentiating between true anorexia nervosa and other psychiatric conditions where weight loss occurs is established by Bruch (1966) in the examination of 43 anorectic patients. She found that with 13 patients whom she considered anorectic orginally, she felt were not typical anorectics because their prime concern was with the eating function which was used in various symbolic ways. These patients exhibited conflicts in conversion hysteria and psychoneurosis. Young schizophrenics in whom noneating is the outstanding feature was more difficult than the
preceding to differentiate from true anorexia nervosa. In the remaining 30 patients "the main issue was recognized as a struggle for control, for a sense of identity and effectiveness, with relentless pursuit of thinness as a final step in this effort" (p. 557). In this article Bruch began to separate eating disorders and established what later became known as primary anorexia nervosa (Bruch, 1970).

In a more recent work Rollins and Piazza (1978) examine the diagnostic criteria for anorexia nervosa and propose a review of the standards for diagnosis which should be neither too inclusive nor too restrictive. They found that the following symptoms and features have appeared in clinical studies in the past decade:

1) severe weight loss resulting from not eating
2) fears of becoming fat or Bruch's "relentless pursuit of thinness"
3) obsession with food and eating
4) high physical activity level
5) distorted body image
6) amenorrhoea
7) low incidence of male cases
8) resistance to growth and change
9) depression.

These features have also been present in the findings by others reviewed in this section concerning diagnosis. The
conclusions reached by Rollins and Piazza and proposed for possible standards in the diagnosis of anorexia nervosa present an accurate picture of diagnostic criteria. They "advocate a weight standard of 20% of body weight loss, and/or weight loss to 20% or more below expected weight for height for age" (p. 136); amenorrhea in females because it was ubiquitous; "that the body-image distortion is basic, and such symptoms as fear of fatness and the relentless pursuit of thinness are outgrowths of the distortion" (pp. 136-137); and "the syndrome can be viewed as a developmental deviation of the normal adolescent process" (p. 137).

The material presented in the preceding pages illustrate the similarities and the differences in the diagnostic criteria of anorexia nervosa. The need for uniform standards as presented by Rollins and Piazza would help alleviate the difficulties encountered when comparing clinical studies. This would certainly be a tremendous contribution to the uniformity in the study of anorexia nervosa.

Theories Relating to the Causes and Onset of Anorexia Nervosa

The research of the past ten years dealing with the causes and onset of anorexia nervosa establishes a distinct division between the psychoanalytic and family systems theories. The nature of the circumstances and family in which an anorectic lives plays an important part in the
development of the illness. This section will expand on the theories and causes relating to the onset of anorexia nervosa by examining the literature in the field.

Anorexia nervosa is not a new illness. The first published account of a case of anorexia nervosa was written in 1689 in England by Richard Morton. This work, *Phthisiologia: or a Treatise of Consumption*, describes in detail the case of a young woman's illness and her subsequent death. The emergence of anorexia nervosa as a clinical entity came about by the independent reports of Lasègue in 1873 in France and in 1874 in England by Gull (Bruch, 1973). This paper is not designed to examine the historical development of anorexia nervosa but these early studies are mentioned here to establish the historical perspective of the illness.

Collecting information on precipitating events and the early symptoms of the anorectic patients was a major goal of the research of Casper and Davis (1977). They found that there was usually some event in the home which precipitated the onset of anorexia nervosa such as: a departure of a sibling, a separation or loss of friends, a family member's illness, going away to school, or a marriage. These events proved to instill doubt in the patient's self-esteem and self-concept that resulted in feelings of powerlessness and loneliness. Patients became concerned and preoccupied with themselves and their physical development and appearance. Often patients could remember
painful comments about a "round face" or a "tummy" which initiated the decision for a diet to begin. Body size contributed to the patient's general unhappiness and dissatisfaction. Casper and Davis stated that all of their patients had the idea of dieting in the back of their minds before they became anorectic. Feelings of relief and happiness were often expressed by the patients who had systematically and successfully reduced their weight by restricting food intake. The patients express their depression and unhappiness with their lives through anorexia nervosa by changing a surface item - their appearance.

In a similar article Garner, Garfinkel, Stancer, and Moldofsky (1976) stress that attention must be paid to the individual's specific body image disturbance and to their related feelings of helplessness.

A disappointing experience is often a sign to a patient that she has an intolerable fault which she immediately seeks to remedy by regressing to recreate herself (Galdston, 1974). In order to prepare herself for adolescence, the anorectic patient tries to establish the dominance of her mind over matter - matter being food. As with Casper and Davis, Galdston noticed that anorectics showed a lack of pleasure with their current lives. His patients also admitted to a deliberate decision to not eat based on two reasons which they were obsessed with: being too fat; the other, eating was bad.
Hamilton (1975) views anorexia nervosa as an example of a failure in adolescent adaptation. She claims that it is a paradox because anorexia nervosa usually is starvation in the midst of plenty and emotional deprivation in the midst of love and concern. Psycho-sociological factors according to Bruch (1978) attribute to the spread of anorexia nervosa. She sees anorexia nervosa as a disease which affects young, healthy girls who have been raised in privileged, sometimes even luxurious circumstances. These girls are often overwhelmed by the many potential opportunities left open for them by their families. The demands on a teenage girl are tremendous in today's society and the greater sexual freedom may be a factor in the greater frequency of anorexia nervosa. Here, as with Casper and Davis, there is a precipitating event which Bruch says is often a film or a lecture on sex education which tells the girl what she should be doing but what she doesn't feel ready for. Bruch stresses that the strong emphasis placed on slimness in our culture and a desire by young girls to "fit in" are contributing factors in the onset of anorexia nervosa.

The Philadelphia Child Guidance Clinic headed by Salvador Minuchin is one of the leading institutions conducting research in the area of anorexia nervosa. Minuchin, Baker, Rosman, Liebman, Milman, and Todd (1975) place anorexia nervosa in the category of a psychosomatic ill-
ness. They reject the linear model of psychosomatic illness - that being that the individual's life circumstances connected to emotions and then to bodily illness. Here the illness is contained within the individual. Theories developed at the Philadelphia Child Guidance Clinic show that looking at the individual to understand the causes and onset of anorexia nervosa is far too limited. They have begun to look beyond the individual to the individual in her social contexts and to the process of feedback between the individual and context. Because of this work a less restricted conceptual model, the open systems model, evolved. This model has directed researchers to a better understanding of psychosomatic syndromes and to the discovery of more effective treatment.

Broadening the focus from the sick child to the sick child within the family has been of prime concern (Minuchin et al., 1975). Minuchin redefines the nature of anorexia nervosa and the scope of the therapeutic change. This shift in emphasis is possible because certain types of family organization are directly related to the onset and continuance of a psychosomatic illness and that the child's psychosomatic symptom plays a major role in maintaining the family's homeostasis. The way the family interacts may trigger the onset of anorexia nervosa. Changing the family interactional process and the use of the symptoms in the family is therefore a necessary goal. The model
holds that the child's family has four transactional characteristics: enmeshment, overprotectiveness, rigidity, and a lack of conflict resolution; and, that the sick child plays an important role in the family's patterns of avoiding conflict, an important source of symptom reinforcement.

A review of the literature dealing with anorexia nervosa and the psychoanalytic theory is presented by Sours (1974). Sours discusses the work of other psychoanalytic therapists, mainly Selvini and Bruch. In agreement with Bruch, Sours states that anorectics have disordered psychological functions. The body image and concept of the body contribute to the disturbances of delusional proportions in the anorectic; there are disturbances in the accuracy of the perception or cognitive interpretation; and, there is a paralyzing sense of ineffectiveness. Sours reports that Selvini views the anorectic as perceiving the body as a threatening entity which must be controlled. Her developmental model focuses on the overprotectiveness of the mother who has difficulty seeing the daughter as a separate object where the child develops a sense of ineffectiveness in her thinking and actions.

Sours (1974) divides the anorexia nervosa syndrome patients into three distinct groups. The first cluster of patients which is most frequently described in the literature is primarily the middle to late adolescent girl. In
this group the syndrome exhibits the girl's "ineffective ego structure, instinctual fixation and infantile object dependency" (p. 570). Female sexual "wishes push these girls back to primary object relations and pregenital drive discharge" (p. 570). The child is so overpowered by her ambivalence to her mother that she refuses to eat as a way of attaining autonomy and self-effectiveness. For these girls "attachment means passive submission to the maternal object with a sense of dedifferentiation and fusion" (p. 570). Because of the power of the mother over the child, this type of anorexia nervosa patient withdraws in order to become separate. She expects that she can lose her instinctual drives through starvation. "Her ego ideal is that of a sexless, affectless and perfect autonomous being" (p. 572). The second group consists of mostly pubescent to mid-adolescent girls. These girls experience oedipal feminine wishes which lead to regressive solutions. Getting distance from sexual feelings and fantasies and aiming toward an oral-aggressive position gives these girls a fear of loss of the maternal object. These activities and feelings all combine to bring about the onset of anorexia nervosa. The third group of anorexia nervosa patients comprise males, who are less common than either of the preceding groups. These boys too have strong ties with their mothers. But unlike anorectic females, anorectic males try to control their sexual feelings to-
wards their mother, to kill the incorporated mother, and to eliminate his body fat and subdue his passive-feminine wishes through the refusal of food and starvation.

The theories and formulations concerning the causes and onset of anorexia nervosa are many, but the research has dealt primarily with the psychoanalytic theory and the family systems theory. The material just presented establishes the beginning of the division among the people studying anorexia nervosa. The lines are fairly well-drawn between the schools of thought but there is some overlapping of the psychoanalytic into the family approach. This will be illustrated later in the section dealing with treatment. The belief of what brings about anorexia nervosa in an individual plays an important role in the type of treatment recommended for each person.

Characteristics Attributed to the Anorectic and the Family

Having looked at the criteria for diagnosis and the theories concerning the onset and causes of anorexia nervosa, it is vital to examine the characteristics often attributed to the anorectic and her family. In previous sections discrepancies among researchers over issues or terms were obvious, but when reviewing the literature on characteristics of the anorectic and her family, it becomes clear that this is one area of general agreement. There seems to be a cluster of characteristics which
typify the anorectic and her family. These characteristics will be examined in this section to aid in the understanding of the person who is anorectic and her family.

An outstandingly good and quiet child would be a comment made about an anorectic before her illness (Bruch, 1966). She would have been helpful, clean, eager to please, obedient, precociously dependable, and excel in school work. These children were the pride and joy of their parents and great expectations were held for them. After their "robot-like obedience" (p. 561) during their childhood, their need for independence, which confronts every adolescent, produces what appears to be insoluble conflict. They lack an awareness of their bodily sensations and their own resources concerning their thoughts and feelings.

Like Sours, Bruch (1966) emphasises the importance of the mother in the anorectic family. The women are often achievement or career oriented and frustrated in their aspirations. Their concept of motherhood is often a conscientious one. They are often not truly respectful of their husbands and yet are in many ways subservient to them. The fathers, usually both socially and financially successful, often consider themselves to be second best. They are usually preoccupied with outer appearances and expect proper behavior and measurable achievements from their children.

A complex mother-child relationship where hostility
is never shown by the child toward the mother is described by Hamilton (1975) as an important factor in the anorectic family. Aggression by the child is usually minimal before the illness with eating being the only area of contention. These mothers see their children as gentle, stubborn, and sensitive; yet they see them as being definitely less independent than their other children. The careers of the children are often dictated by the parents causing the child to retreat into study to avoid conflict with the parents.

In a fascinating study by Bruch (1969), anorexia nervosa is presented in two families with monozygotic twins. Her research reveals that the parents of the twins viewed the anorectic twin as having always been the weaker of the two. Throughout their lives each anorectic twin was described as smaller, slightly more difficult to raise, and a follower. She had received more maternal care, and yet the mother felt more pride and satisfaction toward the other twin. Both twins were intelligent, but the anorectic twin didn't receive as much recognition because the other twin was always the better student.

An unusual case of anorexia nervosa in both identical twins is examined by Debow (1975). The dominant twin began her dieting as a means of gaining approval and friendship from a group of peers with whom she'd been quarrelling, and she persuaded the dependent twin to join
her. The problems of establishing separate identities complicated the psychological issues in this disturbed family. Here, as with other anorectics, the core issues of the anorectic patient persist: "disturbance of body image, misinterpretation of body stimuli and a sense of ineffectiveness" (p. 217). These twins exhibited a wealth of hostility toward their parents through their eating behavior and in physical abuse toward their father. The mother had difficulties interacting with the father and in expressing caring feelings with the twins.

The Middlesex Hospital Questionnaire (MHQ), a self-rating inventory of psychoneurotic symptoms and characteristics, namely anxiety, phobic, obsessional, depression, somatic, and hysteria, was given to the parents of primary anorexia nervosa patients (Crisp, Harding, & McGuinness, 1974). The parental psychoneurotic morbidity, the maternal anxiety and the parental depression, is increased during the illness of the child when the marital relationship is judged to be poor. Sometimes the daughter's illness protects one or both parents as well as the patient if the parent's relationship is threatened by the prospective independence of the child. The ultimate prognosis of the patient seems to be related to the psychoneurotic status of the parents. This study supports the view that "anorexia nervosa in adolescents is often importantly and dynamically related to parental and family psychoneurotic
In a study of 31 anorexia nervosa patients, Beumont, George, and Smart (1976) divide them into two groups: "'dieters' and 'vomiters and purgers'" (p. 617). Dieters are those anorectics who had become emaciated because of food refusal, excessive exercise, and dieting. These patients exhibited clinical features different from the vomiters and purgers. The dieters were often more introverted, intense, and socially withdrawn individuals whose onset of anorexia nervosa was in response to psychological stress. They had become preoccupied with eating, losing weight, and thoughts of food. The second group, vomiters and purgers, brought about their weight loss through the additional use of purgatives (laxatives) and vomiting. These individuals were considered to have a more outgoing personality than did the dieters. Most of these patients had at one time been obese and couldn't control their weight through abstaining from food, and began a dramatic method of controlling their weight through the use of laxatives and vomiting. Patients who consistently vomit after overeating have a worse prognosis than others because of the psychopathological problems concerned with impulse control (Crisp et al., 1974).

Anorexia nervosa patients exhibit themselves as less anxious, depressed, phobic, and somatically uncomfortable than a group of depressed females of comparable age (Stone-
This study supports the view that anorexia nervosa is not a variant of a depressive illness. The anorexia nervosa patients score high in the Eysenck Personality Inventory (EPI) on the neuroticism scale and strikingly low on the extraversion scale. This reflects the social isolation which characterizes the majority of anorectics. In the follow-up, 4-7 years later, the patients mostly recovered from their anorexia nervosa and weight phobia were substantially more phobic in a social sense. The habitual vomiters displayed more obsessional features. These findings add support to the view that "anorexia nervosa is a defence against maturational demands of adolescence, such that when it no longer operates patients present instead with social anxieties rooted in rekindled adolescent turmoil" (p. 192).

Using the personality inventories Smart, Beumont, and George (1976), present data that supports the theory that anorexia nervosa patients are higher in neuroticism, anxiety, and independence. They also tended toward being more introverted and had obsessional features while having a normal intelligence.

Personality structure is an important factor in the prognosis of anorexia nervosa patients (Goetz, Succop, Reinhart, & Miller, 1977). In a study of 30 patients seen 5 to 20 years following treatment, the hysterical group's social adjustment is rated as far better than those pre-
viously diagnosed obsessive or schizoid. These personality traits and defense mechanisms were established in an earlier report by Lesser and used in this study. There are three classifications: group A - predominantly hysterical - histrionic, determined, willful, manipulative; group B - predominantly obsessive-compulsive - rigid, perfectionistic, ritualistic; group C - predominantly schizoid - apathetic, withdrawn, suspicious, silent.

Social adjustment is rated as good - adequately functioning in the community without detectable psychiatric disease; fair - emotional malfunction while participating in the community; and poor - psychiatric disturbance resulting from morbid impairment. The results reflect that the largest group containing 14 patients diagnosed as hysterical have good social adjustment and that "the healthier the family, the healthier the patient, the better the prognosis" (p. 602).

Goodsitt (1974) reports that the anorectic patients he has treated are poorly individuated and have not become separate from others. The mother assumes that the daughter is an extension of herself and discourages the daughter from growing in her own direction. The anorectics have blurred and unstable boundaries for themselves; therefore, upon entering adolescence, a battle develops between the daughter and the mother over who has the rights to the daughter's body. Not eating gives the daughter the con-
control she wants of her own body.

A family's intrusion into the anorectic's autonomy is stated by Minuchin, Baker, Rosman, Liebman, Milman, and Todd (1975) as a contributing factor in the development and maintenance of anorexia nervosa. Often areas of psychological and bodily functioning stay the concern of others in the family long after they should have become unnecessary or automatic, or both. There is agreement that the child grows up in an environment which sets the stage for the development and growth of the symptom. The control over the anorectic is often maintained in the name of concern and protection. Lacey, Stanley, Crutchfield, and Crisp (1977) add that the preoccupation with weight and fatness symbolizes the patient and her family's inability to cope with her adolescent maturation turmoil. Concern with dieting is common among adolescent females but becomes obsessive in those females who go on to develop anorexia nervosa.

Anorexia nervosa patients have difficulty judging the actual size of their bodies. Bruch (1973) feels that it is necessary for a patient to have a realistic body image before recovery from anorexia nervosa is possible. Many anorectics after eating a small meal experience fullness, abdominal distension, and feelings of pregnancy (Crisp & Kalucy, 1974). Such perceived factors may be attributed to the following factors: 1) the previous experience of
weight and shape; 2) the meaning of this shape for the individual; and 3) the potential for reality testing and of responding to the reassurance of others instead of denial tactics involved in irrational fears. The recovered patients in this study exhibit "better social adaption, more critical and realistic appraisal of self and important others, much better impulse control and a general sense of integration and stability" (p. 356).

Previous research has suggested that normal females do not overestimate their body size whereas anorectics do (Button, Fransella, & Slade, 1977). In this study of 20 anorectic patients there is sufficient data to make the point that a body perception disturbance may be more the norm than the exception in today's society. A body perception disturbance may not be a specific criteria for anorexia nervosa, but it may reflect an abnormal sensitivity about body size associated with such things as the anticipation of an undesired weight change, an extreme concern about slimness, and anxiety about putting on weight.

There are exceptions to the type of person and family which takes on the anorexia nervosa syndrome. This section gives an overview of the more typical characteristics of the individual and her family caught up in the illness.
Behavioral Therapy in the Treatment of

Anorexia Nervosa

Because of the dangers of severe malnutrition and death in anorexia nervosa patients, weight restoration is of immediate concern in treatment (Garfinkel, Moldofsky, & Garner, 1977). Behavioral therapy is therefore used in nearly all treatment programs for anorectics. It is used in inpatient and outpatient programs, family as well as individual therapy. Immediate success in weight gain does not insure a long term cure for anorectics (Pertschuk, 1977). The ultimate goal in the treatment of any anorectic is to initiate and maintain normal weight and normal eating habits while the anorectic is functioning adequately in daily life. This section will explore the various behavioral therapies used in the treatment of anorexia nervosa. Patients gain weight rapidly with behavioral therapy without harm, yet there is no evidence to suggest that it is a better treatment modality than other methods (Garfinkel et al., 1977). Not all patients with anorexia nervosa benefit from behavioral therapy.

The most consistent reports of successful treatment of anorexia nervosa have described behavior modification, either with or without the use of drugs (Halmi, Powers, & Cunningham, 1975). "The behavioral therapy has been that of operant conditioning with positive reinforcements, consisting of increased physical activity, visiting privileges,
and social activities, contingent on weight gains" (p. 93). Some researchers have also used desensitization procedures with a behavior modification program. Since most cases of anorexia nervosa treated with behavioral techniques received drugs concurrently, Halmi et al. chose to do therapy without using medications. The average hospital stay for eight patients was 6.25 weeks with an average weight gain during hospitalization of 8.83 kilograms or 19.4 pounds. After discharge the patients were maintained on a behavior modification program and individualized positive reinforcers such as special activities or new clothes given by the family until the patient reached a normal weight range. The researchers also encouraged the patients to learn about proper well-balanced diets and the number of calories necessary to maintain a normal body weight. This provided the patient with a necessary eating-learning experience. Their follow-up studies of anorectic patients who received behavioral therapy as inpatients indicated a need for a continuing behavioral modification program after discharge to maintain their weight.

When treating severe cases of anorexia nervosa, hospitalization is generally accepted as important, if not necessary (Blinder, Freeman, & Stunkard, 1970). Hospitalization allows food intake to be brought under environmental control by rearranging the reinforcing contingencies. This factor permits the maximum effectiveness of operant
conditioning techniques in the treatment of anorexia nervosa. The subjects in Blinder et al.'s study were patients on the psychiatric inpatient service of the Hospital of the University of Pennsylvania. After a diagnosis of anorexia nervosa was determined, a behavioral analysis of each patient was done. One similarity among the patients was strongly evident - their hyperactivity.

It was then decided that opportunity for physical activity might be an appropriate reinforcer. Therefore, physical activity was made contingent upon weight gain. No discussion was permitted with the patients concerning food intake or activity. This was to avoid any direct confrontation over eating. In less than a week after physical activity was made contingent upon weight gain, the patients began a rapid and consistent increase in weight. The initial average gain was 4.8 pounds per week for the first three weeks, and after some tapering off, the average during treatment was 3.9 pounds per week.

The powerful use of operant treatment requires caution in its application (Blinder et al., 1970). It is important to note that weight gain can occur without improvement in other significant areas. Blinder et al. report the suicide of one of the patients after a successful 20 pound weight gain but in whom family conflicts had not been resolved. Bruch (1978) emphasizes that treatment cannot begin until all signs of starvation are eliminated. Behavioral therapy
is an attempt to do just that. Bruch (1977) strongly argues against the use of behavior modification because of its damaging affect on anorectics. She views it as a short term cure for a seriously dangerous illness where patients may be provoked into serious psychological damage by the increase in inner turmoil over control of their bodies and their lives. She asserts that behavior modification represents a helpful adjunct in the management of mild cases of anorexia nervosa but should not be used in the treatment of those with recognizable personality difficulties.

In an investigation by Elkin, Hersen, Eisler, and Williams (1973), the effects of reinforcement, feedback, and increased caloric intake were examined in a single-case design with a male anorexia nervosa patient. During all six experimental phases the patient was weighed at a specific time daily, restricted to his room except for a three hour "free" time daily on the ward, and could only eat at mealtime when his meals were presented to him. The six phases consisted of: baseline - 3,000 calorie diet; feedback - 3,000 calorie diet and informed of daily weight; feedback and reinforcement, 3,000 calorie diet - a token reinforcement system where points earned were exchangeable for canteen booklets or time out of room; feedback and reinforcement, 4,500 calorie diet - calorie increase; feedback and reinforcement, 3,000 calorie diet - reinstated
3,000 calorie diet; and feedback and reinforcement, 4,500 calorie diet - reintroduced 4,500 calorie diet. With the use of the above procedure, the results suggest that "feedback on weight, and reinforcement for weight gains were useful techniques in modifying the caloric intake of an anorexic patient" (p. 76). But the most impressive change in calorie intake occurred when there was an increase in the amount of food presented in combination with feedback and reinforcement.

Operant conditioning is used in the initial phases of treatment of anorexia nervosa patients when there is threat of cachexia (malnutrition) and death (Garfinkel, Kline, & Stancer, 1973). Garfinkel et al. stress that the operant conditioning constitutes only one part of the total therapy program. After weight gain has been increased, further treatment is individualized to meet the needs of the patients. This study presents the establishment of rewards for each patient based on the observations of both the nursing and medical staff during the initial seven days in the hospital. Goals were set with the patient for daily and weekly weight gains. Physical activity, socializing off the wards, passes for overnight and weekend visits, and privileges on the ward were specific rewards for meeting goals. Each patient clearly understood that weight gain was her responsibility, therefore eliminating any power struggles which might occur over food between
the patient and the hospital staff. Weight gain was rapid. Operant conditioning techniques help restore proper eating behavior in anorectics. Garfinkel et al. feel that "the key to the treatment is the selection of appropriate reinforcers which must be specifically related to the patient's manifest behavior" (p. 432).

Behavior modification may eliminate the need to use coercive methods for weight gain such as tube feeding or potentially dangerous methods such as the combination of insulin and chlorpromazine in the treatment of severe cases of anorexia nervosa (Agras, Barlow, Chapin, Abel, & Leitenberg, 1974). Rapid weight gain on the order of two kilograms per week is possible when using behavior modification techniques. The experiments reported by Agras et al. were designed to clarify variables determining the eating behaviors of anorexia nervosa patients and to design and recommend a treatment ideal for bringing about weight gain. One variable appears to effect the rapid weight gain when using a behavior modification approach - the negative reinforcing property of the hospital itself. Bruch (1974) claims that most patients would "eat their way out of the hospital" (p. 1421). A treatment regimen where weight gain is encouraged in anorexia nervosa patients must maximize the effects of both positive and negative reinforcement by arranging the environment so that pleasurable activities can be engaged in only if proper weight gain is
made (Agras et al., 1974). Reinforcing events must be determined for each individual and must be contingent upon weight gain.

Bhanji and Thompson (1974) divide the treatment of anorexia nervosa into two phases: the restoration of weight loss and the correction of attitudes toward eating. The lowest weekly weight gains occurred when using primarily psychotherapy or counselling. Operant conditioning techniques were recommended as a means of rapid weight restoration in a nutritional crisis. This study suggests that the use of operant conditioning techniques are inadequate for a long term maintenance of normal weight and eating habits.

Many treatment programs have been devised to cure anorexia nervosa, but the general feeling is that this is an illness which is difficult to treat that has a poor long term prognosis (Williams, 1976). In an interesting but unsuccessful study, Williams describes his comprehensive behavior modification program used in six cases. The treatment program involved a package of behavioral techniques:

1) desensitization to fears of putting on weight and being of normal weight
2) desensitization to fears of disapproval by significant others
3) desensitization to fears of eating
4) desensitization to sexual fears
5) aversion to pleasure at being morbidly thin
6) aversion to abnormal eating behaviour, such as inappropriate food avoidance, stuffing and vomiting
7) a points system on an operant conditioning model to increase wanted behaviour and decrease unwanted behaviour
8) an attempted change in environmental reinforcement contingencies helping to maintain morbid attitudes to eating and weight
9) self monitoring
10) thought stopping
11) assertive training
12) individualized techniques to help with sexual problems. (p. 322)

Williams labels his study as a resounding failure and states that the results were scarcely encouraging enough to try the behavioral program on any other anorectic patients. The techniques used have been successful in other problems but don't seem to work with anorectics. The most important secondary gain in the small sample was that there appeared to be "covert punishment of and
attention from significant others, especially mother, and relief from the responsibilities of adult sexuality" (p. 324).

Two refinements of hospital-based operant conditioning programs for anorexia nervosa are presented by Perkin and Surtees (1976). First, the external controls on the activity of the patient which were imposed by operant conditioning are relaxed in stages as weight increases. This allows the patient to gain more and more self-control. Second, there is re-educative therapy which helps develop covert and behavioral responses for coping with the consequences of weight gain and stress. In cases where weight gain hasn't been maintained after discharge, it is possible that enough time wasn't spent with the patient clearing up social and environmental problems which inevitably bring on or maintain anorexia nervosa. The discharge of a patient must be closely related to the patient's social functioning as well as the weight gain. This, according to Perkin and Surtees, is a considerably broader interpretation of treatment than is usually applied in the behavioral therapy of anorexia nervosa. They recommend that upon discharge an outpatient contract is agreed upon in which the patient must maintain a certain weight (established for each individually) in order to avoid any significant restrictions on her leisure activities.

Bulimia (morbidly increased appetite) is often a
problem which alternates with anorexia nervosa (Monti, McCrady, & Barlow, 1977). Guiora (1967) suggests that bulimia and anorexia nervosa are not two separate syndromes but the extreme ends of the same disorder. These poles can alternate in the same person.

In an important study of these fluctuating behaviors, Monti et al. examine the effects of feedback and reinforcement on the caloric intake and weight of a bulimic anorectic female and the effects of instructions on vomiting and effects of desensitization and contracting on intake and weight. This case differs from previous reports in several areas. First, the patient was a bulimic anorectic. She would overeat and induce vomiting and take laxatives and/or diuretics. Repeat, then alternate that with periods of decreased eating. Second, thoughts which led the patient to feel she was a bad person usually preceded her unusual behavior. The results showed that feedback had a powerful influence on weight gain. And when desensitization was added to reinforcement plus feedback there was a continued gain in caloric intake and weight gain. This report stresses the importance of reinforcing both weight gain and caloric intake stating that this has not been reported in previous studies. The follow up outpatient treatment continued systematic desensitization in conjunction with behavioral contracting regarding vomiting, pill taking, and eating. The contract was only broken six times in six months suggest-
ing that the contract was instrumental in maintaining treatment success. It is necessary to stress here that follow up treatment and effectiveness maintenance are essential in treating anorexia nervosa since many anorectics redevelop symptoms after relatively short term successes (Bruch, 1974).

"The syndrome 'bulimarexia' is exhibited by women who alternately binge (on food) and then purge themselves, by a combination of forced vomiting, fasting, laxative, or amphetamine abuse" (Boskind-Lodahl & White, 1978, p. 84). This syndrome is similar to anorexia nervosa in that eating and purging can be an aspect of an anorectic's life, but in bulimarexia the major manifestation is bingeing rather than starving. Bosking-Lodahl and White content that similar cultural factors contribute to both anorexia nervosa and bulimarexia. Their "general thesis is that such eating disorders may be represented on a continuum with anorexia at one pole, bulimia at the other, and bulimarexia in the middle" (p. 84). These authors suggest a behavior modification approach when used in conjunction with a comprehensive program where the vicious cycle of binge-ing and purging is broken and the woman may experience herself as free of it and in control of her own life and body. A major emphasis in the therapeutic treatment was directed toward an increase in awareness and acceptance of the person's physical and sexual aspects of
her body - also a goal in treating anorectics. In this study Boskind-Lodahl look at bulimarexia, bulimia, and anorexia nervosa through a feminist perspective and adopt the view that treatment should focus on self-esteem and role-definition in a behavioral program.

Hallsten (1965) explored anorexia nervosa as a pathological food avoidance and treated the illness by desensitization using Jacobsen's relaxation technique. At the fourth therapy session on the 36th day of hospitalization, the patient and therapist began work on her fear of gaining weight. Until this point in treatment there had been little significant weight gain. The patient was told to relax as she had been instructed in previous sessions and to imagine herself in a comfortable situation at home. Slowly she was instructed to visualize herself at the table, eating, eating fattening foods, enjoying them, having eaten, and then going and standing before her mother's mirror perceiving that she had gained weight. The patient showed no sign of anxiety during the session. According to the nursing personnel, she ate her entire dinner that evening - a first. She also showed major changes in her eating behaviors and her appetite after therapy session four. Four months after discharge the staff contacted the patient and discovered that the patient had continued to gain weight outside of treatment. It was indicated at that time that the patient had continued good eating
patterns and had made good adjustments to her family and school after desensitization.

In a study of one 20-year-old anorectic, Schnurer and Rubin (1973) found that systematic desensitization is useful and economical in cases of anorexia nervosa where a weight phobia is evident. The weight phobia is primarily related to weight gain and changes in appearance and is an important factor of this treatment program. Schnurer and Rubin claim that the weight phobia is not inherent in all cases of anorexia nervosa, but that systematic desensitization applied to a weight phobia may prove to be the most efficacious. The treatment program was divided into four phases. Phase one calls for the formation of hierarchies of two types where each represents a different set of concerns relating to a fear of obesity. Phase two consists of using the above two hierarchies in systematic desensitization. Phase three involves the gradual increase of calories and phase four begins daily interviews of 5-10 minutes to aid the patient with increased caloric intake. Caution must be exercised when looking at a single case study because only a controlled environment could rule out variables which might have come into play in this study. Treatment for anorectics must be flexible and one must remember that the treatment of choice is not the same for all anorectics. There is probably only a small group of anorectics for whom desensitization is the
right treatment.

The integration of behavioral therapy and psychotherapy, thereby treating both the eating disorder and the psychological problems, are examined by Geller (1975) in an interesting study. The anorectic patient needs a direct modification of her life-threatening, noneating behavior as well as exploration of her thoughts and feelings which contribute to her identity disturbance. Geller proposes to attack both problems simultaneously. The reward system used in the operant conditioning treatment gives the patient a high degree of autonomy. The patient must gain weight in order to receive a reward, therefore shifting the emphasis from the eating behavior to weight gain. No one coaxes, encourages, or threatens the patient. Weight gain is the total responsibility of the patient; there is no struggle. This permits the patient autonomy and provides the patient with an opportunity to increase personal responsibility. There is more to treating anorectics than just increasing their weight. An anorectic needs to examine her self perceptions, to look at her needs and make some decisions about them, and to discuss her self-awareness. This is the role of psychotherapy. The integration of behavior modification and psychotherapy avoids the use of medication, does not require the patient to be isolated or confined to bed, permits individuation by not forcing food intake, and allows the patient to work on
ego deficits while gaining weight during a crisis hospitalization. Psychotherapy begun concurrently with a behavior modification program is expected to be more successful than psychotherapy begun only after weight is assured. Study is needed in this area. Geller hopes that this integration technique will improve the long term prognosis of anorexia nervosa.

The comprehensive use of behavior therapy, individual psychotherapy, and family therapy is reported by Whipple and Manning (1978) in the treatment of anorexia nervosa. This report strongly recommends behavior therapy as a means of insuring immediate weight gain; individual psychotherapy as a way of looking at the patient's cognitive distortions of her body, lack of identity and sense of helplessness and ineffectiveness, and her inability to understand her body and its messages; and, family therapy to explore the needs and conflicts of the family in the hopes of discontinuing their influence on the patient in maladaptive ways. This report discusses a problem encountered in treating nearly all anorectics - refusal of treatment, either in hospital or outpatient. Whipple and Manning encourage the possible inclusion of legal commitment as a portion of the inpatient care, and if necessary, to outpatient follow-up. The patient needs to be assured in this case that treatment is necessary to prevent death or possible irreversible damage to her body.
The various methods of incorporating behavioral therapy and operant conditioning techniques in the treatment of anorexia nervosa have been examined in this section. There is strong criticism from Bruch (1974) concerning the use of behavior modification in treatment, but most behaviorists agree that weight gain through behavioral techniques is just the beginning in the long road to recovery in anorexia nervosa.

**Family Therapy in the Treatment of Anorexia Nervosa**

Having examined the behavioral approach to anorexia nervosa, it is necessary to look at strategies of treatment where the focus is on family therapy. In family treatment the focus is on the family as a system rather than on the identified patient as the sick individual. "Systems theory views mental and psychosomatic illness as the natural consequences of a dysfunctional human inter- actional group" (Caillé, Abrahamsen, Girolami, & Sørbye, 1977, p. 455). The symptom chosen is affected by the sex, age, and individual characteristics of the symptom carrier. The reason the symptom develops and is maintained is found in the system of which the symptom carrier is a member. A system to which humans belong consists of two or more individuals who have an ongoing relationship with each other. The most vital human system in today's world is the family system and the welfare of the individuals in
the system relies on the function or dysfunction of this system. In a dysfunctional system mental or behavioral deviations of one of its members becomes a means of preventing disintegration. The family therapist intervenes in the family to restructure the system in such a way that the symptom is no longer needed.

A leader in the study of anorexia nervosa in the family system, Minuchin (1974, chap. 12) approaches the illness from a different perspective than the traditional psychoanalytic viewpoint. He sees anorexia nervosa as a psychosomatic symptom of family dysfunction surfacing in the identified patient. The symptom may appear as the patient attempts to solve the family's dysfunction or it may arise in one family member because of her life circumstances and then becomes "supported by the family system as a self-maintaining mechanism" (p. 241). Because of these possibilities, it is therefore inconceivable to regard the identified patient as separate from her environmental circumstances. Treatment is then focused on the patient within her family. "The concept of the identified patient changes when the individual is seen as an acting and reacting member of a social system regulated by an implicit structure" (p. 241). The illness is no longer centered on the patient as her symptoms express the problem in the family. The goal of treatment is to change the family system. Therapy is directed toward changing the
family interactions that set off and maintain the patient's psychosomatic symptoms and toward changing the family's use of these symptoms (Minuchin, Baker, Rosman, Liebman, Milman, & Todd, 1975).

The psychosomatogenic family model, developed by Minuchin (1974), includes three factors contributing to the development of anorexia nervosa or other psychosomatic illnesses: 1) a special kind of functioning by the family which is characterized by rigidity, overprotectiveness, enmeshment, and a lack of conflict resolution; 2) the involvement of the child in the conflict between the parents, and 3) possibly a physiological vulnerability (debatable in anorexia nervosa). Treatment goals are formulated based on the family's idiosyncratic transactional patterns. In the case of the Brown family (Minuchin, 1974, chap. 12) with a 10-year-old anorectic, five therapeutic goals were formulated. The first and most immediate goal was to establish appropriate eating behavior. Second, was a transformation in the spouse subsystem in order to establish clear boundaries between parents and children. Thirdly, was a transformation in the sibling subsystem to eliminate the enmeshed functioning and to increase autonomy appropriate to their ages. The fourth goal of therapy in this case was to make possible the formation of effective dyads and triads in the family and to increase the flexibility within the subsystems. And finally,
communications among family members was fostered. These goals were interdependent and worked on as a group to elicit change in the family system.

A major problem in anorectic families is the underlying difficulties between husband and wife. According to Sargent (1979), a fellow at the Philadelphia Child Guidance Clinic, there is always marital discord and sexual discontent in the spouse subsystem which must be attended to in family therapy. This is often done in private sessions with the parents. The core of the Brown family's dysfunction was seen as the inability of the spouses to communicate with each other (Minuchin, 1974, chap. 12). Many strategies must be used to elicit therapeutic change and to facilitate negotiation and resolution within the family. The anorectic child usually functions as a mediator in parental conflict (Minuchin, Rosman, Baker, with Liebman, 1978). "In detouring families, conflict could be avoided altogether by shifting attention to and amplifying protective and nurturant concerns for family members, particularly the patient" (p. 44). This pattern of interaction includes the parents showing protective concern for their children, the children protecting the parents, and the parents and children asking for protective behavior from each other. These behaviors exemplify the concept of children in psychosomatic families being highly involved in parental conflict.
The therapist works toward the awareness of conflict and conflict resolution between the spouses and "facilitates the development of conflict resolution between the parents and the anorectic patient" (p. 105).

A commentary and transcript of a videotape session of an initial interview with a family of an anorectic daughter illustrates therapeutic techniques based on the concepts of structural family therapy (Aponte & Hoffman, 1973). In the report the interventions of the therapists are analyzed point by point throughout the session. "The goal of the therapists is to assist the family to reorganize itself so that its dysfunctional structure will not support the symptom of the child" (p. 1). The family therapist does not diagnose an illness in one family member and attempt to cure that individual, but rather attempts to understand the structure of the family, its patterns of interactions, and finds out how the symptom relates to the structure. The therapist then intervenes to restructure the system in a manner in which the symptom will not be needed. Lunch is served during the session to the family and the therapists. The therapist explores the dyads, triads, and larger groupings in the family to explore the family structure and to reorganize them at the same time. These efforts focused on creating a pathway for the identified patient so that she could eat.

At the Philadelphia Child Guidance Clinic families
are seen on an outpatient basis as well as when the child is hospitalized and is seen as an inpatient (Sargent, 1979). In severe cases referrals are made to the Clinic from Children's Hospital of Philadelphia when anorexia nervosa is diagnosed and family therapy is seen as an integral part of treatment. Sargent (1979) stressed that it's the referring physician's responsibility to convince the family that psychiatric care is necessary and family therapy is part of that care. Most families see the problem as an eating struggle and are resistant to seek therapy for the entire family. Since anorexia nervosa can be a life-threatening illness, families usually agree to "try it" to see if it will help.

During the inpatient phase before the family is seen together, the therapist periodically eats lunch with the patient during the first fews days in the hospital to understand her views on eating and sharing food (Liebman, Minuchin, & Baker, 1974a). The therapist never enters into a power struggle over food with the patient. The therapist explains the behavioral paradigm to the patient which makes access to physical activity contingent on weight gain. All negotiations about food are made between the patient and the hospital staff - leaving the parents out. These behavioral goals are established to assist the patient with autonomy and to develop responsibility for her physical state. A behavior modification program
is designed for each individual patient (Sargent, 1979) as an effective way of avoiding self-defeating power struggles with the family and therapist (Liebman, Minuchin, & Baker, 1974b). The goals of the behavioral portion of treatment are: 1) weight gain, and 2) begin the therapeutic process.

The family therapy lunch session, a technique introduced by Minuchin, is used to initiate the family of the anorectic into treatment (Rosman, Minuchin, & Liebman, 1975). "Eating lunch with the family provides exceptional opportunities for the therapist to observe family members' transaction around eating, and to make on-the-spot interventions to change the patterning of these transactions" (p. 846). There are three goals/strategies of the lunch session: 1) increasing parental executive effectiveness; 2) increasing distance between parents and child/children; and 3) neutralizing family interaction with respect to eating. The family lunch session is an organized "family crisis around the anorexia nervosa symptom which makes the symptom available to direction intervention" (p. 848). There are two models of a lunch session: 1) model 1, the crisis model, is used more often with younger and preadolescent patients when the therapist is trying to point out issues of control and to enable the parents to become more competent; and 2) model 2 is used principally with families with older adolescents.
where autonomy, separation, and differentiation are important to establish. The therapists at the Child Guidance Clinic believe that the lunch session is the beginning of the transition from inpatient to outpatient treatment (Liebman et al., 1974a).

In successfully facilitating remission of the psychosomatic symptom anorexia nervosa and initiating change within the family system, basic elements are necessary in all family lunch sessions (Rosman et al., 1975). The role and concept of the anorectic child within the family must change. The family must see the anorectic as a powerful, defiant, rebellious child rather than a sick, fragile person. The therapist refines and changes the role of one family member who is highly involved in conflict with other family members. The second element involves transforming an eating problem into an interpersonal problem. In this area the therapist stresses that the child won't eat rather than she can't eat. Attention is focused on communication between the parent(s) and child, autonomy and control, and adolescent rebellion against parental authority. And finally, the parents are prevented from using the child's eating problem to detour their conflict. "As this goal is accomplished the symptom can and will be abandoned by the child" (p. 850). Rosman et al. (1975) indicate that the lunch session is effective in initiating change within the family and symptom re-
mission, but that it is not considered to be a cure but a first step in integrating the therapeutic process.

Weight gain after the lunch session is usually significant and the patient is discharged seven to 14 days after the first lunch session (Liebman et al., 1974a). An outpatient paradigm is explained to the patient and her family and the patient is responsible to the parents and herself to follow the paradigm. As long as she follows the paradigm correctly, the anorectic can have control over her eating. The total treatment program begins with a definite plan to get the patient to eat, but the general goal is to help the child establish autonomy and disengage from the conflicts between her parents and become more involved in activities appropriate to her age group. Family therapy usually lasts from four to 10 months and emphasis is placed on the parental dyad. The therapy is intended to create "constructive changes in the family system that make it possible for the family to prevent relapses and to support the continued growth and development of its members" (p. 435).

In outpatient therapy the therapist focuses on the here-and-now experiences of the family members and makes his/her interventions in a manner which will create new experiences in the family so they will view each other as competent and individuated (Rosman, Minuchin, Baker, & Liebman, 1977). There are age and/or developmental
stage-specific goals of therapy around which strategies are organized. For the preadolescent patients (age 9-12) the therapist is concerned with increasing parent effectiveness and building a coalition between the spouses (Rosman et al., 1977; Rosman, Minuchin, Lieberman, & Baker, 1976). For midadolescents, the majority of anorectics, the goals are to foster autonomy and individuation and to eliminate the child’s intrusion into the spouses’ domain. For older adolescents and young adults, the aim is to effect separation from the family.

In a study of 53 anorectic patient seen at the Philadelphia Child Guidance Clinic, 50 of whom continued treatment, 43 made complete recovery from anorexia, four were in fair condition, three were unimproved and were transferred elsewhere for treatment (Rosman et al., 1976). When counting absolute recoveries, Rosman et al. claim 86% successful outcome. Results of the clinical assessment using the same patients show 44 making good adjustment, three making fair adjustment, and three as unimproved. (Definitions of terms are explained in same article). Therefore when counting only the satisfactory adjustments, the outcome is 88% effective. Rosman et al. (1977) emphasize that their "results are a challenge to the sense of hopelessness that has accompanied follow-up on the anorectic patient. Without any doubt, when anorexia nervosa patients are treated within a year of the begin-
ning of the illness with an open systems approach in the context of their family, they can be cured in a short period of time" (p. 348).

Combrinck-Graham (1974) adheres to Minuchin's non-specific model for psychosomatic illness in children—a model in which the psychosomatic symptoms are brought on by dysfunctional family interactions. This model also implies that the treatment goals for families of psychosomatic children will be similar; therefore families with anorectic and asthmatic children will be treated in a similar manner. This study describes the treatment of a child with anorexia nervosa and chronic asthma. The child's treatment focused only on anorexia nervosa and the other psychosomatic illness (asthma) improved as well.

The case of Nancy, age 11, was presented by Combrinck-Graham as an example of a child having both anorexia nervosa and chronic asthma. A history of her illness and her family is covered in depth in the report. The therapeutic goals with Nancy and her family were to get past the life/death crisis, have Nancy's not eating seen as a disobedience rather than a consequence of an illness, draw boundaries between parents and children, and get the parents to allow their children to become more autonomous. The weight loss and gain of the patient was plotted over a 44-week span from a low of 75 pounds to a high of approximately 122 pounds. The turning point of the in-
patient treatment program for Nancy was the family lunch session after which Nancy began to eat. The outpatient phase of treatment centered around stabilizing the structural changes necessary for this family to alleviate its dysfunction. Attention was given to the parents in helping them deal with their conflict and its resolution.

As functional family interactions improved, Nancy began gaining weight and discontinued severe asthmatic attacks. Accordingly this case "supports the hypothesis that psychosomatic symptoms in children serve a function in maintaining dysfunctional patterns in the family system, and that when the system is restructured to alter these dysfunctional patterns, the psychosomatic symptoms improve regardless of the physiology of the illness or its expression" (p. 833).

Crisis-induced family therapy was employed by Barcai (1971) in the treatment of two cases of anorexia nervosa. The first interview with each family centered around a therapist-induced crisis where the therapist tried "to illuminate the family's dynamics, which, once understood, led to an intervention that neutralized the problem of food intake" (p. 286).

Case 1. T., a 14-year-old girl who weighed 55 pounds after a weight loss of 40 pounds during the preceding year was referred for psychiatric evaluation. Family interactions were examined by the therapist and it was noted that family
members were not able to express individual needs directly, but indirect expressions were noted often involving a third family member. Anorexia nervosa was described as an additional feature of a family problem.

Case 2. L., a 12-year-old girl was hospitalized after rapid weight loss from 93 pounds to 49 pounds in a year. This family's life style and relationships were explored. The family had a seclusionist ideology, a strong investment in learning and school success, and wanted peace at all costs. Guilt, rather than discipline, controlled the children, there was a lack of leadership in the family, and L. was engaged in a power struggle with her parents which focused on food.

Upon discharge Barcai permitted both patients to negotiate eating procedures which allowed each girl to be responsible for her own eating. Continued weight gain was noted in both cases as family therapy progressed. The here-to-fore difficult treatment problem of anorexia nervosa was changed by a family therapy approach. Barcai noted that a significant problem, discontinuation of therapy as a reaction to the crisis session, may be minimized by a skillful and experienced therapist. Because of the serious life/death issue, risks are often taken because of the urgent need for weight gain. The author sees three advantages in using family therapy in the treatment of anorexia nervosa: 1) the child and parents
are freed from the fear for the life of the child; 
2) areas of autonomy are established for the child; and 
3) the effectiveness of therapy is demonstrated to the 
family. A technique is used which relabels a symptom in 
such a way to allow the family to proceed with therapy.

A case history of an anorectic and her family is 
reported by Caillé et al. (1977) along with the events 
and analysis of seven therapy session with the family. No 
attempt was made to provide explanations for the disappear­
ance of the anorexia nervosa symptom in the child and no 
specific goals were established during the course of the 
treatment. The systems approach in this case supported 
the therapists who were outside the system to introduce 
disturbing factors which caused imbalance. "The system 
then reacts with a change that must be evaluated before 
the family's homeostasis is exposed to new therapeutic 
measures. The interplay between the therapists' inter­
ventions and the family's homeostatic adjustment continues 
until the family's need for help no longer exists" (p. 464). 
After the treatment ends the family will not be able to 
intellectually explain what happened in therapy to produce 
 improvement in the symptom carrier. Caillé et al. see the 
treatment process resembling the learning process of 
Zen-Buddhism. "The teacher challenges the student with 
unconventional answers to his questions until the student 
has no alternative but to discover his own truth" (p. 464).
Family therapy with identical anorectic twins was reported by Debow (1975). Therapy focused on twin and family dynamics. Attention to family interactional patterns was displayed in the therapy sessions where much hostility was exhibited by the twins toward both parents—especially the father. This report examined the resistance and hostility encountered in a family approach to the treatment of anorexia nervosa. The therapy "seems to have improved family function" (p. 217) and has helped decrease the hostile and negative feelings expressed by the twins toward their parents. During therapy the eating behavior of the twins focused on the need to have equal amounts of food but less emphasis was placed on food as an area of family conflict. The patients gained weight in the hospital but didn't increase the amount upon discharge. No follow up was reported on their progress.

Hall (1975) uses family involvement as a means of obtaining family history and clarifying family dynamics in her treatment of anorexia nervosa patients. She explains the treatment programme and insures the family's co-operation in this work. When family attitudes change in recognizing the need for change and growth in the patient, there is an improvement in prognosis. When change cannot be effected in the family's ways of behaving or in their attitudes toward the patient, long term treatment becomes especially difficult. Parents usually need considerable
help and separate sessions with only the parents are recommended except for occasional joint sessions with the patient.

The entire family situation and not the individual member is where the pathology appears to lie in working with anorectic families (Hamilton, 1975). In five families studied by Hamilton, the symptom appeared after the separation of the parents. The patient's illness provided an effective means of preserving the status quo in the family. The therapist must usher the family into the treatment of the anorectic so that the patient can be effectively treated.

Disturbances within the family system of the anorectic patient has been recognized for a long time (Moldofsky & Garfinkel, 1974). Accepting the premise that the emotional antecedents to anorexia nervosa have their roots in the family system, two courses of treatment have been suggested: surrogate figures such as nurses and doctors attempt to 1) replenish the deficiency of love in the anorectic and 2) improve relationships and communications within the family. Moldofsky and Garfinkel stress the importance of improving relationships and communications within the family. The family and the patient are seen together because the starvation is viewed as a symptom of disturbed family roles. The power struggle between parents and child with regard to eating is clear in anorexia nervosa,
but the struggle includes a "profound resistance to sexual and psychological maturity" (p. 171).

Family therapy in the treatment of anorexia nervosa is recognized as an essential element for any successful long term prognosis and is recommended by most specialists who deal with anorectic patients and their families. Treatment of families and their involvement in therapy varies from an intense commitment to time and communication to a limited knowledge of the child's treatment modes.

**Individual Therapy in the Treatment of Anorexia Nervosa**

The scope of treatment of anorexia nervosa would be incomplete if individual therapy wasn't considered as a treatment modality. In family therapy individual sessions with the patient occasionally become necessary when working with adolescents who are struggling with autonomy and independence (Rosman, Minuchin, Liebman, & Baker, 1976). During late adolescence and early adulthood, Rosman et al. work initially in family sessions but move quickly to individual sessions with the patient to encourage disengagement and self-confidence. This portion of the paper will explore various individual treatments of anorexia nervosa and other treatment modes not previously discussed.

Bruch (1970) uses a therapeutic approach with anorectics which emphasizes the patient gaining awareness of impulses, thoughts, and feelings which originate within
the patient. In the case of a male anorectic patient
who had spent seven years in psychiatric treatment, Bruch
presents details of her "new" therapeutic approach to
anorexia nervosa. She stresses the need for interaction
changes within the family and changes in body concept
and self-awareness within the patient during treatment.
"This approach represents a modification of the analytic
process, with explicit and consistent emphasis on the
patient's developing awareness of thought and impulses
originating in himself" (p. 66). Bruch (1966) labels
her therapy as "'insight-giving' psychotherapy" (p. 566).
Hall (1975) agrees with Bruch's treatment approach and
aims her treatment toward the patient and the therapist
working to learn about the patient's reactions and
feelings. The patient is encouraged to express their
own feelings and ideas and not to be told how they feel.

Psychoanalytic therapy is seen by Sours (1974) as the
way of treating anorexia nervosa and in a long review of
the literature presents several psychoanalytic studies
of anorexia nervosa. Sours believes that adolescent
anorectics can be treated with traditional analytic tech-
niques; however, two other groups, those displaying
"regressive dedifferentiation, possible loss of self-
object separation and mental self-body-self differentia-
tion and reactivation of archaic ego states, frequently
first require auxiliary medical management" (p. 567).
For proper analytic therapy, medical management is necessary for the physically ill anorexia nervosa patient or a therapeutic alliance is not possible, nor free of counter-transferences.

Guiora (1967) presents the psychodynamics of six dysorexia (a combination of anorexia nervosa and bulimia) patients with whom intensive psychoanalytically oriented psychotherapy played an important role in their treatment. He does not expound on his treatment approach, but delves into the psychodynamics of the patients and their mothers, thus leaving us in the dark as to his treatment goals in working with dysorexia patients.

Individual psychotherapy focused on the anorectic patient is one facet of the treatment experience described by Lucas, Duncan, and Piens (1976). The therapist begins by being supportive of the patient and eventually deals with issues such as control, dependence, independence, expression of anger, and ambivalence toward parents. Psychotherapy begins in the hospital and is continued after the patient's release but varies in intensity and frequency as indicated by the needs of the patient. Family work is also essential if the patient is to return to her home environment after release from the hospital. This portion of therapy often ranges from supportive counseling about the family and its interactions to treatment of problems in other family members.
Because of a lack of an inpatient psychiatric unit for children at Children's Hospital of Pittsburgh, the majority of anorexia nervosa patients are seen on an outpatient basis (Goetz, Succop, Reinhart, & Miller, 1977). Therapeutic efforts are directed toward collaborative psychotherapy with the patient and her parents and attention is focused on the feelings and unhappiness which caused the anorectic not to care about living or eating. The patient is seen in individual psychotherapy while her parents are seen in supportive collaborative therapy. Although the efficacy of psychotherapy and psychoanalysis has been questioned in treating anorectics, Goetz et al. see their technique as being effective and note that "prognosis in anorexia nervosa is largely determined by personality structure" (p. 603).

The outpatient anorexia nervosa treatment described by Reinhart, Kenna, and Succop (1972) focuses on the psychological conflict of the patient and her family. The patient and the family are informed of the procedures of treatment and outpatient therapy consists of psychotherapy. Usually separate therapists are used by the patient and her family. The patient is given the responsibility of eating and is encouraged in treatment to become more independent and autonomous. She is given support to "separate herself from her worried and anxious parents" (p. 119).
Psychotherapy is an integral part of the treatment experience of the anorectic patient but the depth, intensity, form, and frequency of interviews varies from patient to patient (Galdston, 1974). Galdston notes that during the acute stage of hospitalization, most patients had difficulty expressing themselves in an open manner and little attempt was made in pressing for personal matters. "The meetings tended to be educational; the therapist referred to the behavior of other children on the ward to show the patient alternative modes of experiencing emotion" (p. 255). With patients who were more open and able to share their experiences, the therapist entered into a more traditional psychotherapy approach and attention given to exploration in present and past relationships and desires and their attendant affects.

Individual therapy is used in the treatment of anorexia nervosa but primarily in conjunction with other treatment modes such as behavioral and/or family therapy. Individual therapy can be helpful in working with adolescents and young adults to disengage from their family and become more self-confident.
Summary of Findings

This review of the literature dealing with anorexia nervosa leaves both the reader and the writer uncertain and perplexed. The difficulty of focusing on the best possible treatment for adolescents and young adults who may die because of the physiological difficulties of anorexia nervosa causes one to search for clear-cut answers to a severe, difficult to treat illness.

The literature reveals two major areas of concern when treating anorectics. The first must be the elevation of starvation in the patient by promoting rapid, safe weight gain in a relatively short period of time (Van Buskirk, 1977). This is achieved primarily by using behavior modification techniques. These techniques are used primarily during inpatient hospital treatment and are usually continued during outpatient treatment to maintain proper body weight. Since most anorectics exhibit hyperactivity, physical activity is contingent on the patient's weight gain. After hospitalization many behavioral paradigms center around activities as rewards for improving weight gain or maintaining proper weight. Blinder, Freeman, and Stunkard (1970) warn that weight gain can occur without improvement in other significant areas. Blinder et al. reported on a case of a suicide subsequent to a
20 pound weight gain but where family conflicts had not been resolved. Bruch (1974) argues against the use of behavior modification techniques in those with recognizable personality difficulties because of its damaging affect on anorectics but does recognize it as a helpful adjunct in the management of mild cases.

Behavior modification techniques are used in nearly all treatment programs for anorectics in bringing about restoration of body weight. Most behaviorists agree that weight gain through behavioral techniques is the beginning of the long road to recovery in anorexia nervosa.

The second area of concern in anorexia nervosa is the long term perspective. The effectiveness of the treatment "in maintaining a safe weight and insuring adequate adjustment over a long period of time" (Van Buskirk, 1977, p. 529) needs to be examined. Many problems emerge when an attempt is made to evaluate the effectiveness of different treatments. Therapists combine many treatment modalities and use whatever they consider to be effective. There is a lack of studies which have uniform measurement techniques and results are often not comparable. One area of discrepancy is in the diagnosis of anorexia nervosa. Van Buskirk (1977) elaborates on the problem areas when trying to compare different studies: diagnostic criteria, methods of reporting weight gain, and improvement criteria are all different. It is therefore virtually
impossible to draw definitive conclusions. Uniform standards of diagnostic criteria need to be established to aid researchers in defining the most effective treatment of anorexia nervosa.

Insuring adequate adjustment centers on the type of therapy enlisted in aiding the patient once weight gain is begun. Two schools of thought emerge - family systems theory and individual psychotherapy. A highly-respected individual therapist, Hilda Bruch, has recently said, "therapeutic involvement of the family is essential in the treatment of most disorders [anorexia nervosa and obesity]" (Bruch, 1977, p. 104). She recommends the recognition and resolution of patterns of interaction within the family which interferes with the anorectic's sense of identity, and the resolution of parental conflicts. This new direction for Bruch, away from totally individual psychotherapy to a combined treatment utilizing family therapy and individual psychotherapy, gives added strength to the value and importance of the family systems approach to treatment.

Generally, the therapist's theoretical background, be it psychoanalytic, behavioral, or family systems, plays an important part in the therapist's choice of treatment. Therefore treatment modalities which incorporate all three take the beneficial aspects of each treatment and use them to aid in eliminating the anorexia nervosa syndrome.
From a family systems approach, anorexia nervosa is a psychosomatic symptom in a dysfunctional family. Minuchin (1974) established a psychosomatogenic family model which includes the anorexia nervosa family. These families exhibit similar interactions which support the anorectic symptom. The anorectic is the symptom bearer for the family and is usually struggling for autonomy and independence for herself. The family therapist looks at the anorectic in her family system and attempts to understand the interactional patterns among family members. Therapy is directed toward changing the family interactions that rise to and maintain the patient's psychosomatic symptoms and toward changing the family's use of these symptoms in their family system (Minuchin, Baker, Rosman, Liebman, Milman, & Todd, 1975). Family therapy attempts to get the family to view the illness as a family problem rather than the identified patient's problem and to change the system which supports the symptom.

Conclusions

It must be concluded that family therapy is essential in dealing with anorexia nervosa. The entire family is affected by the starvation of one of its members and resolution and change are necessary for the family to discontinue its dysfunctional interactions. Depending on the age of the anorectic, individual therapy is valuable in facilitating the anorectic's independence and autonomy.
and possibly her separation from her family. And in severe cases of anorexia nervosa, behavioral therapy brings about rapid weight gain to insure the continuance of the anorectic's life.

**Recommendations**

Counselors, community mental health workers, and other "helping" professionals need to be aware of the increase of anorexia nervosa and recognize the symptoms in order to insure immediate treatment. Since the long term success rate in anorexia nervosa diminishes after the first year of onset, early detection of the illness is essential to the life-long welfare of the anorectic. Community mental health agencies need to educate teachers, parents, peers, and anorectics themselves about anorexia nervosa and aid the "helping" professionals in locating and treating the anorectics in communities. Physicians and psychiatrists must be encouraged to utilize the therapists in their communities who are properly trained in treating this here-to-fore uncommon illness. With places like the Philadelphia Child Guidance Clinic encouraging "other workers in the field" (Rosman, Minuchin, Lieberman, & Baker, 1976, p. 139) to train with them to work with anorectics, we will become recognized as viable facilitators who provide alternatives to psychiatric intervention.

Workshops for teachers and school counselors, "helping"
professionals such as those belonging to Family Forum, and family physicians should be held in Williamsburg to aid in the process of educating the community about anorexia nervosa. All workshop participants should be encouraged to read The Golden Cage by Hilda Bruch.
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