ANOREXIA NERVOSA - IT S NATURE AND TREATMENT: A PHENOMENOLOGICAL INVESTIGATION

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A B S T R A C T

This study examined the psychosomatic syndrome of anorexia nervosa, its characteristics, etiology and effects. In addition the treatment of the disorderwas considered from the perspective of the three psychotherapeutic approaches most commonly applied to it; psychodynamic, behavioural and family therapy.

The historical emergence and identification of anorexia nervosa was briefly described and the emergence and development of the three treatment approaches were outlined. The diagnosis, characteristics, incidence and factors concerning outcome in the disorder were examined. Each treatment perspective was considered in turn by outlining its understandings of human functioning and approach to abnormal functioning in general. Its theoretical stance towards anorexia nervosa was elaborated and the treatment procedures based upon this described. Finally the outcome of treatment within each approach was considered.

A case study method employing a phenomenological approach was used to explore the perceptions and experiences of seven subjects who were or who had been anorexic. In addition the perspective and experience of some of those closely associated with them at the time of their anorexia was also examined. Issues concerning the research method and the selection of the subjects were discussed and the nature of the contact with them and the manner in which the data was collected described.

Data collected from the subjects, their associates, documentation provided by the subjects and observations were analysed into themes which emerged during the process of the data collection. These were grouped into four theme categories comprising: The Self-Physical, the Self-Psychological, the Self and Others and Intervention. The findings in each theme category are discussed in relation to existing literature.

Major findings included an emphasis on issues concerning control and self concept in the disorder, a reluctance to

develop sexual relationships and a continued concern about food, exercise and interpersonal relationships. Vocational choice indicated a preference for welfare-type work. Close family relationships were evident with some confusion apparent about female roles. Treatment experiences in the main tended to be perceived negatively in that they appeared largely controlling and insensitive.

No one theoretical approach to the disorder could be identified as providing a completely comprehensive perspective with each having distinct advantages and disadvantages. Control and self-concept issues were identified as needing to be central to any consideration of anorexia nervosa treatment and it was reiterated that psychotherapeutic treatment needs as much as possible to recognize the unique nature of each case and not be too constrained by prescribed theoretical frameworks.

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CHAPTER ONE

I N T R O D U C T I O N

This Introductory Chapter provides an overview of the major components of the study: anorexia nervosa and the three major psychotherapeutic approaches most commonly applied to it, and develops the research questions. Initially the concept of anorexia nervosa is described, its diagnosis, characteristics and incidence are considered and issues relating to these are identified. Confirming the relevance of historical and cultural contexts for treatment methods, attention is given to early descriptions of the disorder and its treatment. The development and features of the three psychotherapeutic approaches that most frequently are utilized in relation to anorexia nervosa: psychodynamic, behavioural and family therapy, are then briefly described and related to the disorder. Questions arising from a consideration of anorexia nervosa and the treatment approaches applied to it are formulated and the rationale for employing a case study research method which emphasises phenomenological perspectives, in order to address these, is outlined.

Anorexia Nervosa

Anorexia nervosa is a serious disorder with a number of quite distinctive characteristics. According to Bruch (1973) the literal meaning of the concept is the loss of appetite due to 'nervous' problems. Regarded in most of the literature as being difficult to treat, it has been seen as one of the more dangerous problems occurring during adolescence, with mortality rates for cases ranging from 10% to 23% (Van Buskirk, 1977.) Because it is characterized by a number of symptoms the disorder is generally classed as a syndrome (Brady & Rieger, 1975). It affects mainly adolescent girls and young adult women (Bruch, 1973; Van Buskirk, 1977), the majority of anorexics falling into an age range of 10 to 25 years (Minuchin, Rosman & Baker, 1978).

The syndrome is regarded as a psychosomatic disorder (Kaufman & Heiman, 1964) in as much as it includes physiological and psychological symptoms. Physiologically, severe weight loss is the most notable symptom and this is usually

defined as a loss of 25% or more of body weight, (Minuchin et al, 1978). Amenorrhea (i.e. the cessation of menstruation) is also seen as a symptom in post-pubertal girls (Stunkard & Mahoney, 1976). An excess of physical activity is generally evident, and this differentiates anorexia nervosa from malnutrition caused by physical illness or circumstances external to the individual, where severe weight loss leads rather to lethargy (Bruch, 1973). Hypothermia, or the loss of body heat, especially in those in whom weight loss is great, is often a secondary symptom (Minuchin et al, 1978). In some cases sudden episodes of bulimia (i.e. voracious eating) occur, often followed by self-induced or involuntary vomiting and the misuse of laxatives and purgatives (Brady & Rieger, 1975). Various other physical symptoms are frequently evident, with examples of these being an increase in body hair and constipation (Palmer, 1980).

In addition to the physical symptoms, the most notable psychological symptoms are an active pursuit of 'thinness' by controlling food intake (Minuchin et al, 1978) and a dread of gaining weight (Stunkard & Mahoney, 1976). Some (e.g. Bruch, 1973) have considered a distortion of body image to be a symptom central to diagnosis, with the anorexic denying that her emaciated body is in any way abnormal. A sense of ineffectiveness and a struggle for control are also identified as symptomatic by numerous researchers (Boskind-Lodahl, 1976).

The family characteristics of anorexics appear to have some consistency. Anorexia nervosa seems to occur mainly in middle-class and upper-class families where shortage of food is unlikely to have been an issue, at least during the anorexic's lifetime (Bruch, 1973; Minuchin et al, 1978). These same writers do suggest, however, that food and its preparation are likely to be a central concern within the family. Families tend to see themselves as loving and usually problem-free until the emergence of the anorexia (Minuchin et al, 1978). The problem usually begins with an initially reasonable desire to lose weight, with anorexics having often been slightly overweight in childhood, but continues beyond what is seen as reasonable (Brady & Rieger, 1975; Boskind-Lodahl, 1976). The family's picture of the anorexic is usually

one of a model child; obedient, quiet, eager to please and hard-working, until the emergence of the disorder (Brady & Rieger, 1975).

Despite the apparent distinctiveness and clarity of the various physiological and psychological symptoms in anorexia nervosa, diagnosis, for several reasons, has been and still is problematic. One major reason is related to variations in cultural norms. Weizsacker (1937), for example, noted that the religious ascetic tradition of self-denial, especially denial of bodily needs, has existed in many cultures for centuries and in this way self-starvation has been seen as a virtue. In addition, the post-war affluent world and in particular its media have emphasised the desirability of slimness. Describing self-starvation as a 'problem' therefore becomes relative to the meaning ascribed to it by its culture.

Another reason relates to difficulties in differentiating between anorexia nervosa and other disorders, heightened by the range of physical and psychological characteristics involved. There is a tendency to perceive it in relation to such other disorders. Historically, it was linked to tuberculosis by Sir Richard Morton in 1684, although he termed it 'Nervous Consumption' in order to differentiate it (Bruch, 1973). Later, both Gull (1873) and Lasègue (1873) provided a diagnostic description and between them established its modern name which stressed the psychosomatic nature of the disorder. With the discovery in 1914, however, of Simmonds disease, a disorder of the pituitary gland which causes severe weight loss, anorexia nervosa too was presumed to result from hormonal dysfunctioning and attempts were made to discover its endocrinic origins (Bruch, 1973). More recently there has been difficulty in differentiating anorexia nervosa from schizophrenia and depression, both of which can involve considerable weight loss (Brady & Rieger, 1975). Van Buskirk (1977) in criticising some studies of anorexia nervosa stated that a number had included cases which could be diagnosed in terms of those disorders.

Another difficulty relates to problems in establishing which symptoms are primary and which are secondary. For example some writers see amenorrhea as being a separate

symptom (e.g. Crisp & Fransella, 1972) whilst others see it as secondary and resulting from the malnutrition (e.g. Brady & Rieger, 1975). Similarly, constipation, increase in body hair, loss of interest in sexual activity and peculiar food preferences, all relatively minor identifying symptoms, may also be secondary to the malnutrition (Bruch, 1973).

An additional reason for difficulties in diagnosis lies in the fact that one of the most distinctive symptoms, weight loss, is a relative phenomenon. It is established in relation to previous weight, yet sufferers may have been overweight before the onset of the anorexia or it may be difficult to decide at what point the problem began in order to calculate weight loss. Moreover, as Van Buskirk (1977) pointed out, weight loss or gain needs to be seen in the context of age; if at 16 years a girl has lost 25% of her body weight over four years this is more serious than for a 22 year old over the same period who is unlikely to have grown much in that time.

Even an apparently straightforward characteristic like age is likely to be confused, with some cases manifesting appropriate symptomotology being identified outside the most likely age range of 10 to 25 years. (Hall, 1975). It is not surprising then that Bruch (1973) has stated that the concept of anorexia nervosa has become quite blurred. Minuchin et al (1978) highlighted this too when pointing out that not only had many cases in the past been diagnosed as anorexic that were not, but also that many cases had been excluded because they did not fit the definitions accepted at the time.

Taking into account these various diagnostic problems, general indications do seem to be that anorexia nervosa is becoming more prevalent. Although widely described as 'rare' (Stunkard & Mahoney, 1976), claims are being made that it is becoming quite a common condition. Kalucy and Crisp (1977) see it in this way, claiming that it affects one in every 100 women aged 16 to 18 years in the London area. The fact of an actual increase, and if so whether it is due to changes in diagnosis, social conditions, public awareness, fashions in body shape, child-rearing practice, or other causes, is open to considerable debate. What can be stated with some

certainty, however, is that anorexia nervosa has become more widely recognized and discussed; for example, recently a self-help guide for anorexics was published by Pelican (Palmer, 1980), a widely publicized play about the syndrome appeared on New Zealand television in 1980, several articles appeared in 'Broadsheet' a New Zealand feminist magazine (Matthew, 1980; Coney, 1980, Calvert, 1980), an autobiographical account by a novelist was published (MacLeod, 1981), and several letters have appeared in the problem pages of young people's magazines (e.g. 'Photo-Love' 1982).

Anorexia nervosa then appears to be becoming a rather ubiquitous concept. It is defined by a number of characteristics yet there are major difficulties concerning diagnosis, largely because of the number and variety of symptoms involved and the uncertainty of their interrelationships. The compexity of the disorder has lent itself to the emergence of a variety of causative explanations, none of which has proved conclusive. These explanations have mainly emerged from within the perspectives of the different treatment approaches that have been applied to it rather than developing from a independent consideration of the disorder itself. This circumstance is not peculiar to anorexia nervosa, it is the same with various specific disorders (e.g. depression). However, anorexia nervosa represents a striking example of the different understandings which may be developed with regard to a disorder and the different emphases applied in treatment.

The Treatment of Anorexia Nervosa

In considering the treatment of anorexia nervosa it is important to recognize that treatment procedures arise out of concepts of functioning which have social and historical roots. These determine the direction and limits of treatment development (Minuchin et al, 1978). Consideration of past and present treatments of anorexia nervosa therefore must bear in mind the belief systems implicit in them.

In relation to mental disorders in general, it seems that medieval European thought perceived psychological problems as resulting from the commission of sins or possession by evil spirits. Punishment and torture provided penance for the sins and attempted to cast out the spirits (Stafford-Clark, 1963).

Body and soul were seen as separate in Christian thought and the flesh needed to be controlled so that its weaknesses did not permanently tarnish the soul. In the late 18th Century and early 19th Century, in line with other humanitarian developments, a moral therapy involving a process of education and example rather than punishment for psychological problems emerged (Belkin, 1980). Expansion in the understanding, diagnosis and treatment of organic illnesses, heralded by the discovery of the syphilis bacteria in the early 19th Century, then led to an attempt to identify physiological causes for emotional problems too (Stafford-Clark, 1963). When organic causes could not be identified, the disease model was transferred to a framework of psychical illness (O'Leary & Wilson, 1975). Elements of these varying stances are evident in the early reports of treatment of anorexia nervosa, and these reports also introduce issues relevant to more contemporary treatment methods.

It has been suggested that the earliest known report of a case of anorexia nervosa appeared in the writings of a Persian physician and poet, Nizami-i Arudi in about 1155 A.D. (Shafii, 1972). The rather humanitarian approach adopted to treatment seems to be in contrast to the European thinking of the times described above. The case involved a young prince who was refusing to eat and was under the delusion that he was a cow that should be killed. The treating physician, Avicenna, chose not to confront the delusion but rather addressed the young man as a cow stating that he needed fattening before he could be killed. As well, after the first consultation, Avicenna treated the prince indirectly by dealing with his friends and family, thus altering the social context in which the disturbed behaviour occurred. The young man recovered and the delusion apparently disappeared. Shafii (1972) considered that, given the prince's youth, social situation and refusal to eat, he had suffered from anorexia nervosa. However, the existence of the delusion might suggest another diagnosis.

A 17th Century account of a case seems recognizable as anorexia nervosa. The treatment prescribed, however, indicates that it was perceived predominantly as a physical ailment. In 1648 Sir Richard Morton described the case of a girl who died

of a 'fainting fit' (Bruch, 1973). Morton was aware of the emotional content of the problem which he called 'Nervous Consumption', but had treated it by adopting a physical illness model in which herbal preparations and tonics were prescribed to encourage appetite.

Other likely cases prior to the end of the 18th Century may not have been recorded for a variety of reasons. It may be that few were affluent enough to be vulnerable to anorexia nervosa, that since malnutrition was relatively common, self-induced starvation passed unnoticed, or that it was seen as a relatively normal expression of youthful religious fervour. Progress in the field of medicine in general in the 19th Century was echoed with regard to anorexia nervosa. A number of cases were reported which seem recognizable as anorexia nervosa, and in this period the disorder was identified, named and delineated as a syndrome. Aspects of treatment then appear to have similarities with more contemporary approaches, as will be evident in later material. For instance, in 1873 Gull recommended with regard to what a person would eat that "the inclination of the patient must in no way be consulted" (in Kaufman & Heiman, 1964, p.135). He also stated that "the patients should be fed at regular intervals and surrounded by persons who would have moral control over them, relations and friends being generally the worst attendants" (ibid., p.130). Gull appears to have adopted a 'moral therapy' approach, and highlighted the influence of existing social contexts.

Also in 1873, Lasègue noted the significance of social contexts indicating the frequency of family entreaties and the equal failure of these. He saw the presence of these to the extent that they might well even be a diagnostic factor (in Kaufman & Heiman, 1964). Lasègue found patients to be "docile for the least attractive remedies", although "invincible in regard to food" (ibid., 1964, p.149). He also recorded that he knew of patients who 10 years after the origin of the problem were still unable to eat normally. One patient who had recovered, when asked why she could not eat during the period of her illness, replied "I could not, it was too strong for me and moreover I was very well" (ibid., 1964, p.155).

In 1899, Charcot contributed interesting new perspectives,

of relevance to contemporary treatment approaches. The overt treatment model was again physical and the girl was referred to a 'watering place', but Charcot made the firm recommendation that her family not accompany her. This was initially ignored and only after the reluctant parents had withdrawn did she start to recover. Charcot suggested that such patients should always be separated from their families and rare contact with them should be used as a reward after some initial improvement (in Kaufman & Heiman, 1964). These methods not only recognized the importance of family functioning but also were a forerunner of behavioural methods that have been elaborated in more recent times.

These early descriptions of the disorder and its treatment provide a picture of the thinking prevalent at the time. They also reveal many similarities with contemporary perceptions. In the 20th Century, whilst the search for medical solutions has continued, there has been considerable development in treatment approaches to anorexia nervosa, as with other disorders, that concentrate on psychological dynamics. For anorexia nervosa, three psychotherapeutic approaches in particular have been applied in regard to both causative explanations and treatment methods. These psychotherapeutic approaches are psychodynamic, behavioural and family therapies.

Psychotherapeutic Treatment Approaches

The emergence and development of these specific treatment approaches are important to consider in themselves, as each builds its own perspective from which the explanation of causes and the treatment of anorexia nervosa are undertaken.

With the failure of attempts during the 19th Century to find physical causes for the majority of mental disorders, as previously mentioned, the disease model was not discarded but transferred to a psychological framework. Abnormal behaviour was regarded as a symptom of an underlying psychological illness and theoretical explanations were elaborated. Treatment aimed to search for the illness and identify its causes rather than merely treating the apparent symptoms.

At this stage Freud and various colleagues began to develop the concepts of personality and treatment which came

to be known as Psychoanalysis. This approach perceived abnormal behaviour as symptomatic of underlying problems, which related to early experiences (Hall, 1953). It challenged the separation of body and mind implicit in earlier thinking (Alexander, 1939), seeing the mind as possessing power over the body, the functioning of which it might alter to meet needs relating to early experiences. Hysterical paralysis is a clear example of this (Stafford-Clark, 1963). The influence of Darwinian thought led Freud and others to consider reorganization between psyche and soma as being caused by the organism's need to adapt in order to survive (Mt. Sinai Group, 1964), so abnormal behaviour was seen then as a coping mechanism. Modern psychodynamic thinking, which has developed from classical psychoanalysis, although disputing and to some extent rejecting much of what Freud and his contemporaries postulated, still searches for the underlying dynamics of disorders, concentrates on individual functioning, looks to past experiences for the cause of problems, and tends to adopt an illness model with the therapist as 'expert'. Anorexia nervosa in broad terms, is perceived within this framework as an illness based on dysfunctional adjustments between psyche and soma which have their roots in childhood experiences. Treatment focusses on exploring the underlying and historical meanings of the refusal to eat in order to resolve the conflicts associated with these (Bruch, 1973).

Behaviour therapy was developed after the Second World War period from the belief that emotional problems were essentially learned responses and that more adaptive responses to situations could be substituted by new learnings (Wolpe, 1969). Abnormal behaviour was not seen as a symptom of underlying illness, but as a consequence of inappropriate environmental reinforcements. Moreover, the perception of a behaviour as abnormal or maladaptive was dependent on its social context (Kazdin, 1980). Whereas the medical model presumed an expert working directly with a patient, the behavioural model, in line with a more egalitarian philosophy evident in society as a whole, recognized the influence on behaviour of those in everyday contact with the client and attempted to use them to alter behaviour by training them and the clients appropriately (Kazdin, 1980). In this approach anorexia nervosa is seen as

a learned set of inappropriate behaviours that have been reinforced and treatment focuses mainly on shaping more appropriate eating behaviour (Stunkard & Mahoney, 1976).

Family therapy also developed after the Second World War period. In line with sociological thinking, it has directed attention to the social context of problems and underlined the limits of individual power within a system (Belkin, 1980). Behaviour is perceived as a function of the psychosocial context (Walrond-Skinner, 1977) and since the individual is both dependent on and affects the family system as a whole, it is this whole system that must be treated (Boszormenyi-Nagy & Spark, 1973; Minuchin et al, 1978). Family therapy regards balance within the system (homeostasis) as a major focus, as balance is regarded as the family's intention (Walrond-Skinner, 1977).

If the system's balance is upset by an alteration in one individual's behaviour, either the family will exert pressure for the re-instatement of that behaviour or the whole system must adjust to establish a new balance. Treatment is not geared directly to the alteration of the identified patient's behaviour but to establishing a more satisfactory, constructive balance within the family. From the perspective of General Systems Theory, most commonly used in family therapy work, family problems are seen in relation to breakdowns in communication within the system which lead to inappropriate means of maintaining balance. In the disturbed system, communication may be blocked, displaced or damaged (Walrond-Skinner, 1977), so the family is unable to adjust to changing circumstances by establishing a new form of balance. In treating family systems, therapists must be aware of their own social role in relation to the system and also be able to recognise and work with relationships between systems (Haley, 1976). Anorexia nervosa viewed from the family therapy perspective is regarded as an indication of family dysfunction and a breakdown in communication, and treatment focuses on creating a more functional balance within the family system (Minuchin et al, 1978).

Treatment outcomes in psychotherapy can be difficult to determine and many elements impinge on whether it is possible

to provide accurate results regarding success or failure. This difficulty seems particularly relevant to a disorder as complex as anorexia nervosa. Studies relating to the effects of treatment have mainly taken place within separate theoretical frameworks (e.g. Bruch, 1973; Bhanji & Thompson, 1974; Minuchin et al, 1978). Although some studies, such as those by Eckert, Goldberg, Halmi, Casper and Davis (1979) and Garfinkel, Moldofsky and Garner (1977) have attempted to compare treatments based on different theoretical approaches, the results have proved inconclusive. Hsu (1980) in a comprehensive review of treatment outcomes, stated that differences between treatment studies from a variety of approaches seemed to depend on the selection of cases and the assessment criteria employed. No treatment approach emerged as the preferred method. At this stage then it appears that no one treatment approach can be claimed to be the most effective with regard to anorexia nervosa. In addition, success rates for treatment overall cannot be regarded as satisfactory (Bemis, 1978). Whatever the reasons claimed for this in the individual studies, there is obviously a general need to obtain a clearer understanding of the nature of anorexia nervosa which is complicated by the number of factors involved in the disorder and the uncertainty of the underlying dynamics. Until a greater understanding has been achieved, the most effective treatment methods cannot be identified and utilized in therapy. Indeed, it may be that it is unidentified features of the syndrome which render successful treatment so elusive.

The Purpose of This Study

Although anorexia nervosa has been extensively studied then, there would appear to be a great deal yet to be discovered. It has proved difficult to treat, the success rate has not been good and the mortality rate is high relative to other mental disorders in this age group. There is confusion with regard to diagnostic criteria since the relationships between symptoms of the syndrome are not fully known. Moreover, the incidence would appear to be increasing.

Whilst there are some common elements to the understandings and treatment procedures employed with regard to anorexia nervosa, there remain considerable differences of

opinion as to the appropriate method or methods of treatment, since these are linked to general beliefs held about human functioning by the different approaches. The causes of anorexia nervosa remain unclear and the subject continues to elicit extensive debate in therapeutic circles. This is because the disorder provides a fertile battleground, not only for discussion about the relationship between mind and body, but also for the contrasting beliefs of the different theoretical perspectives into which the disorder has been fitted. It is possibly for these kinds of reasons that previously so rare a complaint has been the subject of so much attention of late in the literature of therapy.

Despite the extensive literature, a need still exists for a more direct consideration of the dynamics and causative factors in anorexia nervosa. These may then be translated into appropriate treatment methods rather than methods being applied which have emerged from more general theoretical perspectives. It seems inevitable in the latter situation that perceptions of the disorder will be moulded to fit the particular theoretical perspective involved.

This study attempts further to explore questions of the likely nature and causes of anorexia nervosa in girls and young women by approaching it largely from a phenomenological perspective employing a case study method. This allows the experience of the anorexics themselves and those closely associated with them to emerge without the constraints of a particular explanatory framework forced upon the disorder by any treatment approach or treatment setting. The overall aim in this study is to explore the perceptions and experiences of a small number of anorexic subjects with a view to gaining increased understandings of the disorder and to establishing where these link with those of the major treatment models. In this way selected practices within existing approaches may emerge as being especially relevant for effective treatment. In addition the purpose is to seek to uncover aspects of the disorder in these subjects which are not necessarily accounted for at present in the theoretical explanations and to begin to postulate some possible new theoretical understandings of the syndrome. The case study method has been recognized by

Neale and Liebert (1973) as a useful tool both for questioning previously established beliefs and for exploring the existence of possible new elements; and the phenomenological perspective allows a more intensive individual consideration of unique experiences and perceptions in doing this (Bullivant, 1978).

Initially the extensive literature on anorexia nervosa itself and as it is considered within the major psychotherapeutic approaches will be reviewed in order to determine various themes and viewpoints which emerge from those doing research and therapy on the disorder. Their perceptions of the nature and dynamics of the disorder will be examined, their treatment methods described and reviewed in relation to anorexia and the results of their treatment considered. Then the perspectives which arise from a consideration of a small number of past and present cases of anorexia nervosa will be analyzed through an exploration of their own experience and that of some of those directly concerned in their anorexia. Their perceptions will be outlined and their meanings for their actions and the actions of those around them, both past and present will be examined. This will be done by the identification of themes which emerge from their accounts supported by examples of their own statements, written documents and the observations of the researcher. It is proposed to link these themes with the understandings offered by the three treatment approaches described. In this way it should be possible to identify any other elements of the syndrome present in these cases which are not adequately addressed by any of the approaches but which may be influential in treatment. New elements which might emerge from this consideration of a small number of cases could then perhaps be pursued in a more general research context in order to establish their more general applicability.

CHAPTER TWO

R E V I E W O F T H E L I T E R A T U R E

Having developed the various research questions to be examined in this study: what are the likely causative dynamics of anorexia nervosa and to what extent do the three psychotherapeutic treatment approaches most frequently utilized in relation to it seem appropriate with regard to explanation and treatment, this Chapter considers them in greater detail through an examination of the literature. This material both elaborates the major questions of the study and highlights some of the essential themes to be pursued in the context of the more empirical analysis.

Firstly, there is consideration of the literature on anorexia nervosa itself in relation to its physical, psychological and social characteristics, its incidence, general treatment outcomes and prognostic features. Then consideration is given to the three psychotherapeutic approaches most commonly applied to the disorder. The psychodynamic approach is briefly described from major literature resources, looking at its perspective on human functioning and on psychological problems, then material is reviewed on the approach in regard to an explanation of anorexia nervosa, the treatment procedures adopted and their reported outcomes. Behaviour therapy literature is considered within the same broad format and then family therapy is similarly examined. Finally, there is a summary of what this literature seems to be claiming about anorexia nervosa and its treatment. From this the development of the foundations for the empirical study are elaborated.

Anorexia Nervosa

Characteristics

Anorexia nervosa is characterized by a variety of relatively distinctive symptoms. These symptoms are utilized for diagnosis and an exact determination of the nature of anorexia nervosa is likely to remain problematic while there are conflicting theories as to its origins. It is regarded as a syndrome requiring multi-factorial diagnosis in both the physical and psychological areas (Szyrynski, 1973). Andersen

(1977) has suggested that most diseases are initially regarded as syndromes, or collections of empirically derived symptoms, until their causes are found with the majority of psychiatric disorders in particular being in this situation. The problem that goes with using symptoms as evidence of a disorder is that some features will be more important than others in diagnosis, with some even being dependent on others. Moreover, emphasis given to and understandings of various symptoms will depend on the orientation of the examiner or therapist (Perkin & Surtees, 1976).

The boundaries of the syndrome become difficult to identify since writers do not all apply the same diagnostic criteria. The lack of a rigorous and uniform definition of anorexia nervosa in the literature has been pointed out by among others, Hsu (1980), Van Buskirk (1977), and Vigersky and Andersen (1977). Tolstrup (1975) considers that the widely differing views on the nature and management of anorexia nervosa arose mainly because of the different descriptive criteria used in diagnosis. It may also be postulated however, that different understandings of its nature and management have influenced the diagnostic criteria selected.

The criteria for defining anorexia nervosa have been separated in the literature into physical and psychological symptoms. The central physical symptom is severe weight loss (Bruch, 1973), usually defined as more than 25% of original body weight (Bemis, 1978). Other symptoms may include amenorrhea in post-pubertal girls, growth of downy hair upon the face and body, a low pulse rate and body temperature, hyperactivity (used in the anorexia literature to mean constant, restless activity), bulimia, and vomiting which may be self-induced or involuntary (Feigner, Robins, Gaze, Woodruff, Winokur & Munoz, 1972; Halmi, Goldberg, Casper, Eckert & Davis, 1977). The likelihood of constipation is also noted by, for example, Szyrynski (1973) and a loss of interest in sex, (Boskind-Lodahl, 1976) which may perhaps be more accurately described as a psychological characteristic.

There are some difficulties involved in applying these physical criteria to diagnosis. The exact definition of severe weight loss is problematic. As Bruch (1978) pointed

out, many anorexics are somewhat overweight before they begin dieting, the exact point of the onset of weight loss is usually difficult to determine (Brady & Rieger, 1975; Bruch, 1973), and developmental changes in adolescence may obscure the full extent of the weight loss. The existence of downy hair, slow pulse rate, low body temperature, constipation and loss of sexual interest may be a direct consequence of a state of starvation, as these characteristics also occur in people suffering from externally induced malnutrition (Bruch, 1973; Palmer, 1980; Silverman, 1977). There is argument too as to whether amenorrhea and hyperactivity should also be presumed to result from malnutrition. Some writers reported that amenorrhea mainly occurs early in the disturbance and before there is any appreciable weight loss (e.g. Halmi et al, 1977; Silverman, 1977; Thoma, 1977) while others claimed that it resulted directly from the weight loss (e.g. Boskind-Lodahl, 1976). Bruch (1977) mentioned the particular sensitivity of menstrual functioning to emotional stress, while Vigersky and Andersen (1977) stated that menses resumed at an appreciably higher weight than did menarche, suggesting that the relationship between weight and menstruation was not clear-cut.

Hyperactivity, another physical symptom, has also been widely accepted as a diagnostic factor (Feigner et al, 1972; Halmi et al, 1977; Minuchin et al, 1978), yet Crisp and Stonehill (1976) suggested that this too could be related to the nutritional state. They stated that restlessness and difficulties in sleeping, both usually perceived as aspects of hyperactivity, were common when a subject was experiencing hunger. Together these concerns about the relationships among the physical symptoms raise serious questions about their utility in diagnosis.

A wide range of psychological criteria, of some uniformity yet of equal uncertainty, have also been identified. These include a firm determination to eat as little as possible, a fear of being fat, a denial both of hunger and of the existence of any eating problem, a distorted body image and unusual food hoarding and food handling behaviours (Feigner et al, 1972). The distorted body image notion has been found by Casper, Halmi, Goldberg, Eckert and Davis (1979), Crisp,

Kalucy, Lacey and Harding (1977) and Garfinkel et al (1977) to involve an overestimation of body width. Bruch (1973) and Minuchin et al (1978) also included in the psychological symptoms a sense of ineffectiveness and a struggle for control.

In challenging some of these symptoms in diagnosis, Bruch (1978) suggested that anorexics' unusual food handling behaviours, such as cutting food into very small pieces, were also typical of those suffering from externally induced starvation. She also stated that individually-specific critical weight loss in itself can lead to increased bodily toxicity and associated psychological dysfunction. Although Casper, Halmi et al (1979) found the extent of body image distortion to be greater among anorexic patients, an age-matched female control group also overestimated their body widths, suggesting that this also is not an accurate diagnostic criterion.

In addition to establishing which symptoms may indicate the presence of the syndrome, diagnosis must also exclude any involvement of other major complaints, either physical or psychological, which involve weight loss. Thus, as Ross (1977) pointed out, tuberculosis, malignancy, hormonal disturbances and diseases of the digestive system must be excluded as must psychiatric illnesses where weight loss may occur, such as schizophrenia, depression and obsessive-compulsive neurosis (Brady & Rieger, 1975). Yet, Silverman (1977) included 19 diagnosed schizophrenic subjects in a study of 65 anorexics and Halmi et al (1977) included subjects who were considered depressed or obsessive-compulsive at the time of the anorexia but who had not been formally diagnosed as such previously.

Age is also regarded as a broad criterion for diagnosis. Feigner et al's (1972) criteria stated that 25 years was the maximum age of onset. Halmi et al (1977) restricted patients to those between 10 and 40 years but for them the onset of illness needed to be between 10 and 30 years as was the case with, for example, Bruch's (1973) 60 patients. All of Minuchin et al's (1978) subjects were under 20 years at the time of onset. Lucas, Duncan and Piens (1976) suggested that the later the age of onset the more likely that the disturbance was not anorexia. Not all studies, however, have confined themselves to these age groupings (e.g. Bliss & Branch, 1960)

and this has added to the confusions about accurate diagnosis.

The lack of well-defined, uniform and unique characteristics which indicate anorexia nervosa is clearly a confusing feature of the disorder. Andersen (1977), however, while recognizing the desirability of clear diagnostic criteria such as those presented by Feigner et al (1972), noted the problems that a strict adherence to them could cause in diagnosis, understanding and treatment. He suggested that there were three types of atypical anorexia nervosa (i) where the syndrome is typical but the presentation is atypical, when for instance the age of the patient is more than 25 years at onset (ii) where the presentation is typical but the syndrome is atypical, either quantitively, the subject not having enough symptoms to qualify, or qualitatively, where the symptoms exist but are not severe enough to qualify, and (iii) where neither presentation nor syndrome are typical but no other cause for the weight loss can be found. Andersen felt that diagnosis should be sufficiently flexible to accommodate these variations.

As well as various physical and psychological symptoms, anorexia is broadly identifiable in relation to various social characteristics. It appears to be a predominantly female disorder. The ratio of males to females suffering from anorexia nervosa seems relatively uniform in various studies on incidence. Brady and Rieger (1975) quoted one male to 10 females as did Szyrynski (1973). Six of 53 subjects studied by Minuchin et al (1978) were male, as were 10 of Bruch's (1973) 60, and 27 of Crisp et al's (1977) 350 anorexics.

Anorexics have seemed to come from mainly middle and upper socio-economic class groups and to be high achievers academically. Crisp, Palmer and Kalucy (1976) from a sample from the London area noted that one girl in 200 at private and boarding schools suffered from anorexia whilst in state schools the incidence was less than one per 3,000. Hall (1978), in New Zealand, stated that most families came from what she identified as the middle and upper classes. Halmi et al (1977), in the USA, claimed that there was not one well-documented case in the literature of this disorder occurring in a black

American, and Hall (1978) stated that she had only seen one case of a half-Maori girl in New Zealand and that she came from a socially upward-mobile family. Minuchin et al (1978) also noted the middle class origins of their patients in the USA, but Lawrence (1981), in Britain, made the claim that not all anorexics came from middle-class families. She considered that many were working class by father's occupation, but out of 60 clients seen by her, only one did not achieve at least 'O' level standard at school. Conscientiousness and a high level of intelligence have been found to be common in anorexic patients (Hall, 1978; Boskind-Lodahl, 1976; Bruch, 1973). Silverman (1977) noted that nearly all of his sample were of average intelligence but that most of them were 'overachievers'.

Family characteristics appear to be important in the development of anorexia nervosa, although genetic inheritance did not seem to be a factor as it appears to be, for example, with some obesity problems (Stunkard & Mahoney, 1976). Hall's (1978) study of the family structure and relationships of 50 anorexic patients provided information in the New Zealand context. Parent's ages tended to be higher than in the general population, with this being supported by Bruch (1973) in the American context. Hall found the incidence both of psychiatric illness and physical illness to be more common in parents of anorexics than in the population as a whole, although these problems tended to be under-emphasized by them. This may link in with the denial or minimization of the anorexic problems by the cases themselves, as noted by Feigner et al (1972).

Hall (1978) also found that marital unhappiness was common, a finding shared by Minuchin et al (1978) in the USA, and Kalucy, Crisp, Lacey and Harding (1977) in Britain, and that a uniform picture of social conformity was evident. Bruch (1978) also noted a family emphasis on polite behaviour. This supports the description by Minuchin et al (1978) of rigid, conflict-avoiding families. Some reports mention the particular role of the mother in the family. Szyrynski (1973) mentioned the frequent dominance of the mother, Boskind-Lodahl (1976) and Bruch (1978) commented that many mothers seemed to have been career women who had sacrificed their ambitions for the good of their families.

When considering siblings, Hall (1978) found that the families of her 50 cases contained more daughters than sons. The family size did not differ from that of the New Zealand population in general and contained 112 female children to 48 males. Bruch (1978) found that two thirds of her families contained daughters only. Stunkard and Mahoney (1976) stated that there was a high incidence of anorexia among sisters, but in only two of Hall's families was this evident, when older siblings had developed and recovered from mild anorexia nervosa. In the light of the apparent increase in the disorder, this does not suggest a high concordance.

Incidence

Recent evidence suggests that the incidence of anorexia nervosa is increasing, although it was formerly believed to be a relatively rare disorder (Brady & Rieger, 1975; Stunkard & Mahoney, 1976). Szyrynski (1973) for example, estimated that one in 300 cases referred to psychiatric hospitals and clinics were anorexic. Kalucy et al (1977) described the disorder as affecting one in every 100 sixteen to eighteen year old school girls in and around London.

Bruch (1978) stated that over the last 15-20 years the incidence of anorexia nervosa had increased at a rapid rate. She found that whereas her patients in former years had no knowledge of the existence of anorexia nervosa as a diagnosed disturbance, very few young women she now saw were unaware of its existence. She also suggested that the increase in the problem might be partially associated with an increased emphasis on slimness, especially for adolescents. Palmer (1980) noted a considerable increase in the professional literature on anorexia nervosa, which was proportionately greater than the increase of such publications in general. However, he pointed out the difficulty in distinguishing a real increase in the incidence of the disorder from an increase in referrals for treatment arising from a greater consciousness. Kalucy and Crisp (1977) pointed out that the typical avoidance of medical attention and denial of illness characteristic of those suffering from anorexia nervosa made it difficult to estimate the incidence and both Lawrence (1981) and Palmer (1980) suspected that for these reasons those identifie represented but a small proportion of the problem.

Treatment Outcomes

In the literature, a great deal of uncertainty surrounds questions of treatment outcomes and prognosis. Considerable variation occurs among the different treatment approaches and where it is possible to identify the approach being used then attention will be given to these findings under the categories of the treatment methods themselves. However, a number of general confusions surround these questions.

As Van Buskirk (1977) pointed out, criteria for outcome vary a great deal according to the stance being taken to the problem and the treatment approach utilized. The extent of this led Hsu (1980) and Thoma (1977) to claim that it was impossible adequately to compare studies of outcome. The difficulty is accentuated by the fact that there are wide variations in the different patient populations studied, as pointed out by Crisp et al (1977) and Vigersky and Andersen (1977), with Russell (1977) seeing this as a function of the treatment settings and referral agencies as much as of the therapists and any diagnostic confusions.

Variations in follow-up time periods were also pointed out by Crisp et al (1977) and Vigersky and Andersen (1977), with the former stressing the fact that the problem of anorexia may fluctuate over a considerable time span and being supported in this by Russell (1977) and Theander (1970). Hsu (1980) also raised questions about follow-up studies indicating that information for these was often incomplete and Ross (1977) saw them as often being more impressionistic than factual.

The various procedures utilized in outcome studies also raise important questions. Given the tendency for subjects and their families to deny the existence of problems, the contacts made by letter or telephone and information provided by relatives in Russell's (1977) and Brady and Rieger's (1977) studies, for example, make the results questionable. Similarly, Bhanji and Thompson's (1974) postal questionnaire to the General Practitioners of anorexic patients leaves considerable room for doubt about the results. Other instruments such as the Middlesex Hospital Questionnaire as used by Crisp et al (1977) or the Anorexic Attitude Scale as used by Halmi et al (1979) have limitations in the extent to which they impose general

cultural values on the concept of normality.

Acknowledging these limitations both in general and as they apply to studies undertaken within specific treatment frameworks, it seems to be widely regarded that anorexia nervosa is difficult to treat and that a high relapse rate is likely (Brady & Rieger, 1975; Bruch, 1973). There is also a relatively high mortality rate for cases - claimed by Brady and Rieger (1975) to range between three and 20%, Minuchin et al (1978) 10-15%, and Van Buskirk (1977) 10-23%. Russell (1981) makes the statement that there is no solid evidence to suggest that any treatment alters long-term the natural course of anorexia nervosa.

A reasonably extensive study undertaken by Theander (1970), making no distinction among various treatment approaches, considering 94 patients treated between 1931-61 in a variety of settings, and incorporating a relatively long-term follow-up in that data were obtained a minimum of six years after treatment, arrived at the following results. It was found that 44% could be regarded as recovered although only 17% could be regarded as being mentally healthy; 39% suffered from mild anorexia and/or considerable symptoms of other mental distress; and 17% had either died or were still suffering from severe anorexia nervosa.

Prognostic Factors

Keeping in mind the major limitations of outcome studies, the work involving the determination of prognostic factors can be considered. A study by Russell (1977) provides a useful starting point since subjects were only given general nursing care and supportive psychotherapy of a non-specific kind. It was therefore suggested that outcome could be seen to reflect the natural course of the illness influenced only by the general care received. Russell found that a later age of onset, lengthy duration of the illness and disturbed family relationships all indicated a poor outcome. Behaviour in the hospital setting and changes occurring during hospitalization did not seem to predict long-term outcome, and nor did intelligence, feeding difficulties in childhood or obesity prior to the anorexia. In contrast to other studies, such as Theander's (1970), self-induced vomiting did not seem to influence outcome.

Late age of onset was identified by Crisp et al (1977) as indicative of poor outcome. Minuchin et al's (1978) highly successful results with a younger sample group than most might be seen to support this, as might the finding that being married is indicative of a less positive outcome (Crisp et al, 1977). The prognosis has been considered to be worse among males by Crisp et al (1977) and by Bruch (1973), and among those from lower socio-economic groups. This latter feature seemed to be related to difficulties in establishing what were regarded as appropriate therapeutic relationships with these patients and their families. It may also partially explain the finding of Garfinkel et al (1977) that inadequate educational and vocational adjustment, which included poor or non-attendance at school or work, was linked to less positive outcomes.

Contrary to Russell (1977), Crisp et al (1977) found pre-morbid obesity to be indicative of a poor outcome, possibly because it indicated an inability to accurately gauge nutritional needs. Bulimia and vomiting also for them suggested a poor outcome and this was supported by Garfinkel et al (1977) and Bruch (1973). This may be associated with previous hospitalizations which also predicted a less successful outcome (Garfinkel et al, 1977; Halmi et al, 1977) since Bruch (1974) suggested that bulimia and vomiting behaviour often began after treatment which emphasised rapid weight gain.

Not surprisingly, Crisp et al (1977) found that motivation for treatment indicated a good prognosis. This factor may also be linked to the number of previous hospitalizations since patients would be less likely to be as optimistic of receiving help after first or subsequent courses of treatment. Motivation for treatment also presupposes acceptance that a problem exists and therefore is likely to involve less denial of the problem which was found by Halmi et al, (1979) to indicate a good outcome. Denial may also be linked to a failure to recognize hunger, which for Halmi et al (1979) was found to be indicative of a poor prognosis.

Garfinkel et al (1977) considered body size perception to be indicative of outcome, as assessed two to eight years after cessation of treatment. They argued that distortion

of body image is also linked to a denial of thinness. Casper et al (1979) also found that the greater the overestimation of body size the lower the weight gain over a five week period. Halmi et al (1979) found that a great amount of hyperactivity was predictive of a good outcome, but since the study measured weight gain only over a short period, this might be related to enforced restriction of exercise during hospitalization. Goldberg et al (1977) found less sleep disturbance, also linked to hyperactivity, to contribute to a positive outcome. Halmi et al (1977) found, contrary to expectation, that greater weight gain was associated with a smaller weight loss in the disorder. This finding might suggest that the smaller weight loss was related to the less serious nature of the problem or to its more recent development.

Finally, along with these many and varied prognostic indices, family factors have also been seen to play a part. Crisp et al (1977) noted the frequency with which anorexics came from families where other members suffer from weight disorders or who control normal weight by excessive exercise. They suggested that this might indicate a poor prognosis. They also suggested that excessive rigidity in the family and anorexic alike predicted a less positive outcome. This finding is similar to that of Minuchin et al (1978) who found that families of anorexics seemed to be resistant to change.

A consideration of the characteristics, incidence, outcomes and prognostic factors in anorexia nervosa leads naturally to an examination of treatment. An examination of the disorder in the context of the three major psychotherapeutic approaches follows. In each case a brief introductory section describes the theoretical framework in order to provide a context for the review of the particular approach as it is applied to anorexia nervosa.

Anorexia Nervosa and Psychodynamic Therapy

A Brief Outline of the Theory

Contemporary psychodynamic approaches to the explanation of personal functioning and treatment have their roots in Freudian thought. The Freudian concept of personality perceived the individual as having a finite amount of energy which must be expressed (Brown, 1961). This proposition is

drawn from discoveries in Physics which were especially influential during Freud's professional formative stages in the late 19th Century. It is held by Freudian dynamicists that energy forces known as instinctual drives must emerge through various channels (Hall, 1954). The personality is seen as being comprised of three components, the super-ego, ego and id. Where energy forces arise out of the id, or unconscious mind, the direct expression of which is unacceptable to the ego, or conscious mind, the force is channelled by the use of defence mechanisms into a more acceptable field. The individual is seen as a complex whole in which the various parts work to balance each other. Changes to one part of the system will bring about changes elsewhere and the unconscious mind can alter physical as well as psychological functioning to meet its needs (Alexander, 1939).

The ways in which an individual establishes balance are seen as being developed early in life (Wolman, 1972). During the first years of life the individual must pass through stages of development each of which focuses energy into a different body location and has accompanying psychological features (Freud, 1905). In the first stage, termed the oral stage, attention is focused on the mouth and feeding activity and the baby experiences itself and its environment through its mouth. The concept of infantile sexuality holds that sexual energy is already present at this stage and is linked to the mouth and feeding. One of the tasks of this stage is to begin to differentiate between the self and others, at first perceived as one, and by so doing to begin to recognize the limits of individual power (Klein, 1936). The baby is believed initially to phantasize its power as being unlimited. During the anal stage, which follows the child begins to learn bodily control and to develop a more realistic picture of its own capabilities. In the third stage, referred to as the phallic stage, the child learns to identify with the parent of the opposite sex and to fix the locus of sexual interest and activity in the genital area. This task, which begins at about age four and lapses during the period of latency, is resumed with the advent of puberty and what is referred to as the genital stage.

Psychodynamicists see problems in human functioning as arising from inappropriate channelling of energy into areas which ultimately prove detrimental or destructive to the individual (Alexander, 1963). Therapy involves locating the suppressed direction for the energy force, exploring it so that its functioning is raised from the unconscious to the conscious mind and finding a more appropriate means of expressing it. They believe that dealing only with the symptoms of the dysfunction will ultimately lead to another inappropriate expression of the energy elsewhere, referred to as symptom substitution. They argue that the underlying cause must be treated in order for this not to occur (Brown, 1961).

Problems with regard to the expression of energy arise when the tasks to be completed in each stage of development are not successfully achieved. This results in fixations -- which then interfere with functioning at later stages. Difficulties to do with feeding, for example, are usually presumed to stem from the oral stage and fixation at this point may involve a failure to differentiate between feeding, sexual activity, and aggression. Inappropriate patterns of balance are laid down in early life, such that "later traumatic experience will only result in pathological symptomatology if during psychic development a scar remained which sensitized the patient to the later emotional shock. Therefore all pathological manifestations of a psychosomatic nature have their roots in the past" (Deutsch, 1927/1964, p.51).

In psychosomatic illnesses, the ego is seen as having adapted normal functioning in order to spare and protect the total organism from some stressful situation, the chief function of the ego being to maintain "physiopsychosociological balance" (Mt. Sinai Group, 1964, p.97) and to achieve optimum constructive tension through an arrangement of least expensive compromises.

More recent advances in psychoanalytic thinking with regard to personality development, dysfunctioning and treatment have concentrated on exploring the individual's relationships with others. (Sullivan, 1953). Emphasis

continues to be on early life and, in particular, relationships and their impact on later functioning. Therapists are more likely to use their own relationships with their clients to explore past relationships and to 'repair' failures which appear to emerge (Brown, 1961). Anorexia nervosa, for example, is seen in some of its elements as resulting from a failure to establish adequate boundaries between the self and others through inappropriate communication in the early part of life (Bruch, 1973), and this difficulty with self-other boundaries will inevitably be manifested within the patient-therapist relationship.

Any examination of the literature on the psychodynamic approach as it is related to anorexia nervosa, its nature and treatment, poses particular problems for a reader. A vast amount of material which covers a considerable time-span offers a variety of perspectives which can be difficult to compare or relate to each other. At times the complexity of concepts presented dominates the writing so that cases are used largely as illustrative material of concepts and it is frequently difficult to determine a writer's overall perspective on anorexia nervosa or the extent of and nature of contacts with actual cases.

Anorexia Nervosa as Personality Dysfunction

Anorexia nervosa is seen as a dysfunctional organization of the personality in this framework and attempts have been made to categorize it as such. However, there is disagreement among psychodynamicists as to the type of personality dysfunction it is. For example, Tolstrup (1979) suggested that anorexic cases could be divided into four groups: obsessive-compulsive neurosis (which he regarded as the core group); hysterical neurosis; psychotic borderline states; and endogenous depression. The symptoms are likely to be similar but the underlying personality formation is seen as different. Chediak (1977) used three groupings: obsessive-compulsive; hysterical; and schizoid, but also recognized that 'borderline personality organization' had begun to be used as a category. Bruch (1973) used this latter category to distinguish anorexia nervosa from schizoid difficulties, seeing it as involving personality

disorganization of a milder nature. Sugarman, Quinlan and Devenis (1981) also supported this distinction, recognizing the existence of tenuous boundaries to the personality in anorexia nervosa whereas in schizophrenic conditions they saw the boundaries as not existing.

Several writers have discounted these kinds of divisions. For example, Stonehill and Crisp (1977) stated that since anorexia nervosa should be recognised as an attempt to avoid the turmoil of adolescence, emphasis on any pre-existing personality structure was often inappropriate. Bruch (1978) supported this more functional emphasis, suggesting that the apparent severe ego defects (splitting of the ego) and depersonalization were related more to the starved state than to any pre-existing personality structure. For her, the sense of being divided related to the hidden and denied self's existence which the anorexic disapproved of, the struggle being enacted by the mind's attempts to control the despised body. Lawrence (1981) also noted the ongoing struggle between the divided personality which she perceived as being divided into the sensible side and 'the other' side. She stated that treatment needed to recognize both and work towards their integration.

It can be seen that there is no clear agreement on the type of personality formation involved in anorexia nervosa nor on the value in attempting to categorize it. There appears to be, however, a shared emphasis on the importance of and difficulties in establishing appropriate boundaries of the self. The psychodynamic approach to anorexia appears to fall mainly into two schools of thought. The first of these can be termed the psychosexual stance and the second the ego psychological stance.

The psychosexual stance. The basis for the psychosexual approach to anorexia nervosa lies in Freud's assumption that impairment in the nutritional instinct is related to the organism's failure to master sexual excitement (Ross, 1977). Rampling (1978) suggested that food and eating assume a significance they held early in life when orality and sexuality were linked, with Chediak (1977) believing that the eroticization of the eating function indicated massive regression.

Fears of oral impregnation are apparently common in otherwise well-informed anorexic girls (Grote & Meng, 1934; Syrynski, 1973), and not eating was also seen by Ceaser (1977) as a defence against oral sadistic and libidinal impulses, that is an unconscious desire to destroy by biting and swallowing.

The refusal to eat is also seen as the denial of a wish to incorporate (Ceaser, 1977), incorporating being the process by which 'objects' (e.g. food, emotions) outside the self are taken in and made part of the self. Learning to achieve this appropriately, without either being overwhelmed by the environment or overwhelming it, is perceived as a task of the oral stage. Ceaser stated that anorexics have failed to internalize (incorporate) the loved maternal object, and Sugarman et al (1981) suggested that alternate bingeing and vomiting behaviour was a concrete representation of a need to incorporate the mother (food) and then express oral rage towards her by rejecting her (vomiting). Chediak (1977) saw the anorexic as struggling to gain a sense of omnipotence, seen by Thoma (1977) as being sustained by the hyperactivity, which serves to avoid a pervading sense of helplessness and the anorexic's fear of being overwhelmed by her own needs (Chediak, 1977). Some writers have believed that the constipation frequently associated with anorexia is part of a desire to maintain a sense of self by the retention of body products (Rampling, 1978; Sugarman et al, 1981).

In addition to assertions concerning regression to the oral stage, some writers have commented on anorexics' relationships with their mothers which, within the psychosexual stance, would be seen as involving fears related to the phallic stage. Hostile, ambivalent impulses towards the mother were noted by Szyrynski (1973) and linked with sexual anxiety, the mother being perceived as aggressive and castrating. Grote and Meng (1934) also commented on oedipal and castration fears as playing a major part in the development of the disorder. Crisp and his co-workers (e.g. Crisp & Fransella; 1972; Stonehill & Crisp, 1977) also highlighted the issue of sexuality, however they have preferred to identify the roots of anorexia less early in the individual's life. They have perceived it as an attempt to avoid puberty and adult sexual

functioning and a return to the safety of pre-pubertal functioning. The cessation of menstruation which both Szyrynski (1973) and Thoma (1977) claimed occurred early in the illness is seen as indicating regression through abandonment of the genital stage (Thoma, 1977). The four cases reported by Ceaser (1977) all had unpleasant sexual experiences immediately prior to the onset of the anorexia. Bruch (1978) would seem to agree that the illness is an attempt to return to childhood size and functioning, but she found a fear of pregnancy as a sexuality component not to be an issue in her cases, concluding that fears of adult sexuality were not paramount. Selvini Palazzoli (1978) stated that in her view sexual fears in anorexics were almost invariably an expression of their fear of psychological invasion.

The aim of treatment in the psychosexual model focuses on conscious understanding of the psychosexual conflict, allowing a more constructive energy balance and a movement through to genitality and continued psychophysiological development, (Thoma, 1977).

The ego psychological stance. The ego psychological approach to anorexia appears to stem largely from a viewpoint of interpersonal dynamics and contends that inappropriate learning in the earliest stage of life leads to an inadequate awareness of self and the self's needs. Bruch (1970) stated that awareness of hunger is learned and that this is achieved through early "reciprocal transactional feedback" between mother and child. Both obese and anorexic clients do not easily recognize sensations of hunger, she claimed. She saw this failure as being related to the mother's not allowing a transaction to take place because she anticipated every need and totally controlled the interaction so that the child did not learn to identify sensations or initiate actions with regard to these (Bruch, 1978). The refusal to eat thus becomes both a failure to recognize own needs and an attempt to reject external control. The rigid self-discipline and denial of hunger are seen as an indication of the fear of a lack of inner control (Bruch, 1977). Selvini Palazzoli (1978) stated that the anorexic shows a keen desire, however distorted, to become autonomous by rejecting the self as a passive

vessel, but is unable to rely on her own sensations to decide when to eat. Lawrence (1981) perceived the emphasis on control of the body as an avoidance of dealing with other control issues in the anorexic's life. Within this ego psychological framework, amenorrhea and constipation and even hyperactivity serve to illustrate issues to do with control over the self (Bruch, 1973).

Anger and hatred towards the self are also seen as significant by several writers within this stance. Selvini Palazzoli (1978) saw the 'I am too fat' message as a concrete expression of dislike for the self and Lawrence (1981) also commented on the anorexic's poor self-image. Geller (1975) made reference to a client who stated that her refusal to eat was connected with anger at herself, and Chediak (1977) mentioned cases in which there were signs of minor mutilation. Thoma (1977) commented that some anorexics would refuse good food but eat scraps from dustbins or even shoe polish, suggesting that they did not think that they deserved better. Boskind-Lodahl (1976) felt that a poor self-image, involving a fear of rejection in intimate relationships, resulted in anger towards the self which was expressed in terms of bingeing and vomiting. She also noted a lack of a sense of identity. A distorted body image, as noted by, among others, Feigner et al (1972), can also be seen to demonstrate self-hatred and a lack of a clear sense of self.

The aim of treatment within the ego psychological stance focuses on the encouragement of autonomy (Crisp, 1980; Lawrence 1981; Palmer, 1980), the development of self-awareness, competence and effectiveness (Bruch, 1970, 1979) and the improvement of self-image (Boskind-Lodahl, 1976).

<u>The families of anorexics within the psychodynamic framework</u>. Recognition of the importance of family functioning in anorexia nervosa is evident in the earliest general literature on the disorder and was clearly stressed by both Lasègue (1873/1964) and Charcot (1889/1964). The dilemma of how to handle family involvement remains. Various writers in the psychodynamic framework when considering the anorexic patient have attempted to characterize family members. Szyrynski (1973) saw the mothers of anorexics as dominating the family, while

the fathers tended to be passive and ineffectual. He also noted frequent conflicts between the grandmother and the mother. Bruch (1978) considered the mothers to be women who had sacrificed their careers for their family. She also stated that mothers, and sometimes fathers, were weight or diet conscious and that many anorexics felt that they had a special responsibility for their mothers. Chediak (1977) noted a shared belief in mothers and their anorexic daughters that the daughter is part of, or is 'owned' by, the mother.

Both Selvini Palazzoli (1978) and Bruch (1977) have commented on the power of the family to disrupt treatment and both have themselves moved over the years to having a greater involvement with the whole family in treatment. Their approach broadly maintains a psychodynamic base, but it has moved from a concentration on intrapersonal dynamics alone.

The Psychodynamic Approach to Treatment of Anorexia Nervosa

In considering treatment studies within this approach, it is at times difficult to be clear on many important factors, for example, what criteria were used to diagnose the case or cases of anorexi (e.g. Sugarman et al, 1981), what the treatment actually involved (e.g. Chediak, 1977), or the extent to which the cases were representative of that writer's experience of anorexia nervosa (e.g. Ceaser, 1977). Bemis (1978) stated that many accounts presented information on a very small number of cases and that aspects of treatment were often unclear. However, some researchers such as Bruch (1973) and Selvini Palazzoli (1978) in their studies provide a much sharper picture of the processes involved and their likely efficacy.

Certain dilemmas are seen to face psychodynamic therapists as they engage in work with anorexic clients. The first of these is the type of therapeutic relationship to be developed and maintained, since this is central to treatment. To what extent should, for instance, classical, analytical interpretive techniques be applied? The second dilemma is the manner in which weight gain is to be achieved - the therapeutic norm in this approach is that treatment is likely to be long and painful, but the therapist cannot allow the patient's weight

to hover at a dangerously low level for much of that time. Thirdly, therapists must determine the involvement, if any, they wish to have with the family of an anorexic. Running through all of these dilemmas is a question relating to the interest in and necessity for combining psychodynamic psychotherapy with other forms of treatment.

The psychodynamic therapeutic relationship. Differences of opinion among psychodynamicists are evident as to the type of therapeutic relationship seen as most appropriate in the treatment of anorexia nervosa. The position adopted by individual researchers and therapists depends to a large extent on the stance, psychosexual or ego psychological, to which they ascribe. Much of the argument here centres on how interpretive the treatment should be.

Bruch (1970, 1977) suggested that the clinical analytical approach involving interpretation provided a painful repetition of previous experiences of being told what to feel or think. Perls (1969) pointed out that in any therapy there is a natural and healthy resistance by the client to "swallowing whole" the therapist's ideas. Selvini Palazzoli (1978) stated that a resistance to interpretation may be expressed through absence from sessions or a refusal to communicate and Thoma (1977) also noted the anorexic's tendency to reject the therapist's prescriptions and recommendations. Rampling (1978) thought this rejection, often seen even in compliance to avoid conflict, related to a fear of losing control to the therapist. Bruch (1977) recommended that patients be allowed to express their own experiences without these immediately being labelled or explained. Conceptual defects and distortions were regarded as needing to be repaired through the relationship but not by interpretation. She also recommended (1978) the use of a humourous, down-to-earth approach to deal with the often stilted and serious anorexic. Chediak (1977) postulated that Bruch's disenchantment with interpretation might be related to a reliance on verbal communication and suggested that interpretive therapy needs to be complemented by non-verbal or pre-verbal interaction. He did not, however, elaborate on the meaning of this.

Crisp (1980) suggested that psychoanalysis has failed to

recognize the regressive nature of anorexia nervosa and instead, through its traditional treatment approach, had worked to increase it, thus assisting puberty avoidance. Ross (1977) noted that the decision as to how analytic, and therefore regressive in orientation, treatment should become was important; experience seeming to suggest that an ego supportive or expressive mode was more successful than a classical, interpretive analysis.

Some of what has been written illustrates the difficulty therapists have experienced in relating to anorexic patients. Rampling (1978) suggested that a psychodynamic understanding would enable the therapist to avoid sharing the patient's belief in her own 'sinfulness'. He also noted the difficulties involved in transferring such a patient to another therapist should the therapeutic relationship fail. Lucas et al (1976) stressed the importance of remaining optimistic and convinced of the patient's desire to recover. Thoma (1977), commenting on the deception and manipulation common in anorexia, stressed the value for the therapist of relying on their own counter-transference feelings as a cue to recognizing the hidden and indirectly expressed feelings of the patient towards them. He underlined the need for a working alliance. Both he and Rampling (1978) emphasised the difficulty in treating a person against their will.

The issue of whether a male or a female therapist was more appropriate in anorexia nervosa has also been discussed in the psychodynamic literature. While Szyrynski (1973) stated that a male therapist could be more effective because he could replace the inadequate father figure and avoid identification with the hostile mother, and Thoma (1977) noted a tendency in female colleagues to mother anorexics inappropriately, Selvini Palazzoli (1978) suggested a female therapist was more appropriate. She considered it would be more difficult for a patient to be open with a male therapist who also risked becoming identified with the weak and neglectful father. Boskind-Lodahl (1976) also suggested that a female therapist could provide an appropriate role model.

An important aspect of the therapeutic relationship in this framework would seem to be related to issues of power. Some therapists such as Lucas et al (1976), Thoma (1977) and Rampling (1978), seem to argue for a powerful role for

themselves. Lucas et al, for instance, suggested the therapist should be involved in establishing the feeding routine and should use information acquired from the nursing staff to confront the patient. Others, such as Boskind-Lodahl (1976), Bruch (1977), Lawrence (1981) and Selvini Palazzoli (1978), have recommended that patients be given more sense of their own power. It is perhaps significant to note that these last four writers are all women.

Achieving weight gain . There is a generally held belief in the more recent psychodynamic literature on anorexia nervosa that psychotherapy cannot be effective if the anorexic is still at starvation point (e.g. Bruch, 1977). It is also recognized that the benefits of psychotherapy are generally not sufficiently immediate to remove the client quickly from danger. Bruch (1978) considered severe starvation to have a considerably disorganizing effect, as it makes it difficult for sufferers to concentrate on anything other than food and renders them apparently inaccessible for treatment because of the semi-toxic state which it induces. In addition therapists cannot work as successfully if they are anxious for the lives of their clients (Thoma, 1977). The question then becomes what means should be used in refeeding and to what extent should the therapist be involved? Tolstrup (1975) and Thoma (1977) both recommended tube feeding in severe cases. Bruch (1977) suggested intravenous hyperalimentation, the use of a high calorie intravenous drip, since it avoided therapist-patient conflict. Geller (1975) combined behaviour modification and psychodynamically-based psychotherapy, using the latter to explore issues aroused by the more active former. In Russell's (1981) account nurses assumed control of the feeding initially. In the Lucas et al (1976) study, food was also rigorously supervised by nursing staff and was organized initially to maintain admission weight, and later to increase weight with periodic increments. Their suggestions echo Gull's (1873/1964) thoughts that firmness and 'moral control' are needed in those who supervise the eating.

Bruch (1978) believed that patients need reassurance that their eating will not be allowed to go out of control

and that a nutritionally sound diet will be provided. She criticized schemes which concentrate on weight gain without reference to the foods involved, since these might encourage the anorexics to eat 'junk' foods which they associate with bingeing. This, she felt, would lead to considerable guilt and self-loathing and accentuate the problem.

Throughout the literature there is fear expressed that therapists might become inappropriately involved in the struggle over food and lose their effectiveness (e.g. Thoma 1977), Lucas et al (1976) involved the psychiatrist in the administration of the refeeding regime and Geller (1975) supervised both psychotherapy and behaviour modification procedures. Szyrynski (1973) however, recommended that the psychotherapist not only be uninvolved in the refeeding but also should avoid mentioning food at all in the initial stages of treatment. Lawrence (1981) avoided involvement in the process of weight gain by using an agreement in which counselling was provided on the condition that the anorexic take responsibility for her own adequate nutrition. Since her clients were all self-referrals, such an arrangement was possible.

Several writers in this framework have perceived a place in treatment for weight gain combined only with supportive psychotherapy (i.e. psychological support without attempts at exploring and dealing with any underlying dynamics). Chediak (1977) considered this to be sufficient in mild cases. Dally and Sargant (1966) used supportive psychotherapy in conjunction with chlorpromazine and insulin. Lucas et al (1976) employed supportive psychotherapy initially but aimed to aid the expression of negative feelings and to consider dependency issues later.

Psychodynamic treatment and the family. As a result of increasing awareness of the family's role in anorexia nervosa, there has been concern as to how best to counteract the effects of this as part of the treatment plan. Szyrynski (1973) suggested that either the family environment should be changed or the patient moved to another environment, stressing the difficulty likely in achieving the former. For this reason hospitalization is often seen as an

appropriate temporary solution (e.g. Lucas et al 1976; Ross, 1977). Selvini Palazzoli (1978), however, cautioned against hospitalization, stating how terrifying and destructive an experience it could be. Lawrence (1981) likened the medical system to the family system itself and suggested that the anorexic's symptoms encourage others to take control of her, either at home or in hospital, when this is really what she is struggling against.

It has appeared to be difficult for some psychodynamic therapists to contemplate treating the whole family as a unit. It is clear that in many cases other family members go on to receive individual psychotherapy themselves (e.g. Bruch, 1978; Lucas et al, 1976) and that some therapists have begun to include family therapy of a kind (e.g. Bruch, 1978; Chediak, 1977; Lucas et al, 1976; Sugarman et al, 1981; Szyrynski, 1973). This family work would appear however, to be supportive in nature and to treat the family as a collection of individuals. The difficulty of changing family behaviour is noted (Szyrynski, 1973). The move from treating an individual to treating the family as a whole has been claimed by Minuchin et al (1978) to necessitate a paradigm shift which naturally is difficult to make. Selvini Palazzoli (1978) however, for one, has documented this shift in her own thinking and therapeutic behaviour.

The use of family therapy, pharmacotherapy and supportive psychotherapy within the psychodynamic framework highlights the issue of the combination of treatment approaches. There is in fact little description of combining treatment approaches in the literature and where they are mentioned there is little explanation of what was involved. Crisp (1981), however, described a combination of behavioural procedures to induce weight gain, occupational therapy, social skills training and small group therapy. Family therapy, where appropriate was also provided. Again however, the family treatment briefly described indicates that families were perceived as a collection of people with individual problems.

Psychodynamic Treatment Outcomes

Many of the general issues previously mentioned about the limitations of outcome studies within the field of

anorexia nervosa relate to the psychodynamic approach, in as much as goals, manners of assessment and follow-up details are usually not clearly stipulated. As well, several writers provide no indication of what were the actual outcomes of their treatment. For example, Chediak (1977) discussed only one case which by implication was successful whereas Sugarman et al's (1981) individual case seemed to be unsuccessful. It is unclear from Ceasar's (1977) study whether the four cases considered were successful in outcome or not.

In considering treatment goals, Crisp et al (1977) underlined the importance of achieving not only biological maturity but also suitable psychological and social adjustment. Sixty percent of the 340 patients they studied up to 17 years after treatment had achieved biological maturity, while approximately 40% had also made a good recovery in psychological and social terms.

Lucas et al (1976) reporting on 32 patients stated that although three patients left the programme against advice, the 'great majority' were improved up to three years after discharge. They do not give figures to elaborate on what constitutes the great majority. They did state that three years was too early to draw any long-term conclusions. Szyrynski (1973) reported on 16 cases treated but did not state how long after treatment they were assessed. Three over 30 years old were considered to be schizophrenic and/or hysteric and improved slightly for a while, one case died, eight recovered and two made partial recoveries.

Of Bruch's (1973) 60 patients, she identified 45 as being clear cases of anorexia nervosa (primary). Of these 25 were followed-up one-to-five years after onset and the remainder six-to-19 years after onset. She was unable to obtain information on six patients and two patients were still in treatment. Four had died (one by accident), four had become schizophrenic and five were chronic anorexics. Twenty-four had established a normal weight but only 13 of these were said to have recovered. Eight of those recovered had developed anorexia before the age of 14 and had received treatment within the first year.

Selvini Palazzoli (1978) divided her patients into two

groups. The eight patients she saw in her early years whilst working at a Medical Clinic were described as serious cases; two of those had died, two were chronically ill, three had stabilized their weight but suffered from neurotic disturbances. One had married and moved away from home. Of the 22 patients seen at her Private Clinic, 13 had been seen at an early stage in the illness. Nine of these she assessed as cured, two suffered from marked mental disturbances, and for two she felt that her own treatment had brought about failure. The remaining nine patients were seen after the anorexia had become chronic, three of these recovered, three had improved somewhat, one had become schizophrenic and two had died. Both she and Bruch (1973) stressed the importance of the therapist's understanding of each individual case in obtaining a successful outcome.

In concluding this discussion of the literature on the psychodynamic approach to anorexia nervosa, it may be said that the wide range of material produced over a considerable period of time offers a variety of perspectives on the disorder. In addition, psychoanalytic/psychodynamic thinking has had considerable impact during that time on the treatment of psychological problems in general and it is at times difficult to determine if a particular treatment should be included in a consideration of the psychodynamic approach or if it may merely be said to owe a considerable debt to psychodynamic thinking. This is the problem when examining the work of Dally and Sargant (1966) for example, where the main part of treatment involved pharmacotherapy but supportive psychotherapy, which is not described but which in a medical setting is likely to be psychodynamic in nature, was also included.

The style of reporting is also problematic in the psychodynamic approach. Writers are concerned mainly with intricately exploring the specific concepts involved and often the number of cases treated, the interaction between therapist and patient, the outcome of treatment and other important issues are blurred. The explanation of anorexia nervosa in psychodynamic terms emerges out of a sophisticated yet complex theoretical scheme which is overlaid on the presenting symptoms to provide causative explanations.

These in turn are related to an intricate therapeutic procedure of similar sophistication and complexity.

Anorexia Nervosa and Behaviour Therapy

A Brief Outline of the Theory

Behaviour therapy is based upon learning theory and was developed extensively after the Second World War. Behaviourism rejected the psychodynamic approach to human functioning, which sought underlying causes for behaviour, and focused attention on behaviour itself as it occurred in the present and on changing behaviour largely by manipulating the environment. Both appropriate and inappropriate behaviours are presumed to be learned, but within the approach the origins of the behaviour have been regarded as no longer central. Attention is given to the factors which maintain behaviour in the present rather than what caused it in the past (Ashem & Poser, 1973).

A fundamental principle of learning theory is that behaviour occurs in response to a stimulus. There are two major systems through which responses are seen to be learned, one being classical conditioning (being based largely on the work of I. Pavlov) and the other, operant conditioning (based largely on the work of B.F. Skinner). Classical conditioning involves the pairing of two stimuli. The first of these, the unconditioned stimulus, provokes a usual response (known as an unconditioned response) which is either innate or previously learned. For example, a door slamming (unconditioned stimulus) may provoke a wince (unconditioned response) in the individual. The second stimulus, the conditioned stimulus, is usually previously neutral (i.e. one that elicits no particular response). In the example, it could be another person putting their hand on the open door, which, when followed by the door slamming (unconditioned stimulus) and the wincing behaviour (unconditioned response), becomes a conditioned stimulus (hand on door) to produce what is then the conditioned response (wincing). The conditioned stimulus-response pattern will be strengthened the more the unconditioned and the conditioned stimuli operate in conjunction with one another, and eventually the conditioned stimulus (hand on door) will in itself provoke the wincing response. However, this will

gradually diminish if the conditioned stimulus continues to occur in the absence of the unconditioned stimulus. This process is called extinction, (Belkin, 1980).

The more commonly known system of learning is that of operant conditioning. In this system, a person's actions, occurring in response to some stimuli, produces a consequence in the environment that either increases or decreases the probability of the initial action occurring again. If the environmental response is experienced as rewarding by the individual (reinforcement) and gets repeated, then the person comes to expect it and the expectation provides the stimulus for the continued behavioural response. If, on the other hand, the environmental response is not experienced as rewarding by the individual (e.g. punishment) and gets repeated, then the person comes to expect it and the expectation provides the stimulus to avoid the initial behavioural response. For example, if a child achieves well in school and the teacher praises the performance publicly, then provided it is experienced as positive the child will continue to strive to achieve highly and the more the two are linked the more likely the pattern will be maintained. If, alternatively, the public praise is experienced as negative, then the child will strive to avoid achieving highly. Within this approach behaviour is seen as very much a function of its consequences (Skinner 1938).

Reinforcement and punishment, which are central concepts in the operant learning system can be further subdivided. Positive reinforcement involves the occurrence of a pleasurable response from the environment (e.g. praise). Negative reinforcement involves the removal of an unpleasant situation from the environment as a response to behaviour (e.g. release from isolation). Punishment involves either the occurrence of an unpleasant event (e.g. corporal punishment) or the removal of a pleasant one in response to behaviour (e.g. no television time) (Kazdin, 1980). Both reinforcement and punishment, however, need to be determined individually for each person, as what may act as a positive reinforcement for one may be a neutral stimulus or even punishment for another.

In the behavioural approach, behaviour is not in itself disturbed, rather it is regarded as adaptive or maladaptive as a consequence of social determination. A behaviour,

therefore, may be adaptive in one situation and maladaptive in another. The principles governing the acquisition, maintenance and change of behaviour are the same no matter what the social determination. Maladaptive behaviour is changed into more appropriate patterns on the basis of learning theory. As Kazdin (1980) stressed, this involves a broad sequence of careful observation and assessment of the behaviour that is to be altered, intervention, and evaluation of the effects. Intervention in the behaviour therapy approach involves a variety of methods, with the most usual being operant conditioning, systematic desensitization, implosive therapy, and additional related techniques e.g. shaping, modelling.

Anorexia Nervosa as Maladaptive Behaviour

In behaviour therapy anorexia nervosa is perceived as learned behaviour and often described as a weight phobia or as excessive avoidance behaviour (Ross, 1981). The excessive weight loss and many of the accompanying symptoms are readily identified as maladaptive. Hallsten (1965) provided a useful case example of the principles involved within the learning theory framework. The girl in the case was teased about being fat, to which her response was to become anxious. In order to reduce this anxiety she began to diet and was praised by her family which reinforced her non-eating behaviour. Subsequently she lost too much weight and her family criticized her for this which again made her anxious. By this time, however, her manner of dealing with anxiety about being fat had become generalized and so she reacted to this present anxiety also by more dieting. In order to alter this pattern the anxiety related to eating and gaining weight needed to be reduced. This could either be achieved by providing reinforcement for eating behaviour more powerful than that which was provided for not eating (operant conditioning), or the anxiety could be reduced by linking eating and weight gain with a response, such as relaxation, which would be incompatible with anxiety (systematic desensitization). Both of these methods have been recommended for the treatment of anorexia nervosa (Eckert et al, 1979; Stunkard & Mahoney, 1976).

In considering anorexia nervosa, therefore, the behaviourist is not concerned with establishing the cause

of the pattern or with understanding the personality structure but in altering the identifiable behaviour - usually the failure to eat.

The emphasis given to eating behaviour in this approach is perhaps understandable; it is the most directly observable behaviour, is, beyond a certain level, clearly maladaptive, and because of its significance to survival, is the most urgently in need of alteration. Arkin, Ackerman, Morris, Rabkin and Rosenberg (1976) have also stressed that behavioural techniques are at their best in shaping discrete, easily delineated target behaviours. It is considered that psychological functioning itself will improve with weight gain (Blinder, Freeman & Stunkard, 1970). Kazdin (1980) though, has noted that the most easily identifiable behaviour may not be the most appropriate choice as the target behaviour. It is possible that behaviour therapists on the whole have concentrated on eating and weight gain to the detriment of other aspects of the disorder. Recognizing that anorexia nervosa is essentially a syndrome, some researchers (e.g. Williams, 1976) have attempted to change concurrently other behavioural aspects of the disorder while still others (e.g. Perkin & Surtees, 1976) have recommended a two-phase approach to treatment, the first focusing on weight gain and the second addressing other related behaviours such as self-assertion.

The families of anorexics in behaviour therapy. There is some reference to the families of anorexics in the behavioural literature but this is relatively limited and brief. Where behaviours concerned with issues of independence and autonomy are mentioned, these are generally related to the family situation, such as with Brady and Rieger, (1975), Geller, Kelly, Traxler and Marone (1978) and Perkin and Surtees (1976). The overprotective nature of the families of anorexics was noted by Perkin and Surtees (1976), with Whipple and Manning (1978) commenting on the symbiotic mother/daughter relationship found with anorexic patients. However Bemis (1978) and Brady and Rieger (1975), referring to family relationships, suggested that the disturbed parent/child relationship frequently noted in anorexia nervosa may be the result of rather than the cause of maladaptive eating

behaviour.

The family as the source of environmental reinforcement for inappropriate eating behaviours should, in theory, be of considerable significance to behaviour therapists. Since treatment in this approach, however, has usually isolated the anorexic from her normal environment by placing her in hospital (e.g. Brady & Rieger 1972; Eckert et al, 1979; Perkin & Surtees, 1976; Pertschuk, 1977), the baseline observation period has by default excluded the family and reinforcement schedules have then been selected on the basis of the clinical environment. The importance of the family has seemingly only been indirectly recognized; hospitalization was recommended by Pertschuk (1977) for instance, because it interrupted inappropriate interaction concerning eating in the home and Bachrach, Erwin and Mohr (1965) employed family visits as a reinforcement for appropriate eating behaviour. Where direct family involvement in treatment has been described (e.g. Perkin & Surtees, 1976; Williams, 1976) this has tended to be brief and to consist of relatively general requests to the family to alter their interaction with the patient.

The Behavioural Approach to Treatment

As previously stated, two behavioural treatment approaches are mainly utilized with regard to anorexia nervosa; operant conditioning, the most frequently applied, and systematic desensitization.

Operant conditioning uses reinforcers which are contingent on eating or weight gain. Reinforcement may be positive or negative and punishment may also be employed. Positive reinforcement is regarded as the most desirable and punishment the least (Kazdin, 1980). Eckert et al (1979) suggested that in operant conditioning the anxiety related to eating will diminish with the repetition of experiences associated with a reinforcement.

Systematic desensitization, which is based on the principles of classical conditioning, usually involves substituting a response, such as deep muscle relaxation which is incompatible with the maladaptive anxiety behaviour associated with eating. Deep relaxation is taught and a

hierarchy of anxiety-producing images or situations ranging in levels of intensity is drawn up by patient and therapist together (Ross, 1980). These are then introduced, beginning with the least threatening, while the patient maintains a relaxed state. The aim is to move progressively up the hierarchy working at the point where relaxation continues to inhibit anxiety, repeating the procedure until the whole hierarchy can be experienced without anxiety (Wolpe, 1969).

Operant conditioning. As Blinder et al (1970) pointed out, in operant conditioning with anorexics hospitalization is normally regarded as essential, since the non-eating behaviour is regarded as an operant maintained by established environmental circumstances; (Blinder et al, 1970; Blue 1979) This is seen as providing safety (Pertschuk, 1977), the possibility of strict environmental control (Blinder et al, 1970; Geller et al, 1978; Steele, 1976) and relief from unproductive interaction at home (Pertschuk, 1977).

Although the choice of target behaviour in operant programmes has concentrated on eating behaviours, there has been some variation in whether the focus should be food intake or weight gain. Bachrach et al (1965) and Bhanji and Thompson (1974) both focused on food intake. Bachrach et al (1965) found however, that the patient ceased to gain weight as she began to vomit surrepticiously after meals. They then changed their target behaviour from food intake to weight gain. Weight gain is regarded as less likely to encourage the patient to vomit (Eckert et al, 1979; Poole, Samson-Fischer and Young 1978; Stunkard and Mahoney, 1976), avoids direct confrontation over eating itself which has usually been the pattern before admission (Blinder et al, 1970; Eckert et al, 1979), and is easier to monitor than 24-hour food intake (Eckert et al, 1979).

The choice of reinforcements has also varied. Most have related to physical activity although verbal praise and encouragement were used by Agras and Werne (1977), Bachrach et al (1965), Geller et al (1978) and Steele (1976). Blinder et al (1970) stated that during an observation period hospitalized anorexics walked nearly seven miles per day, whereas they assessed that norman women in the community walked five miles per day and non-anorexic hospitalized women considerably

less. This suggested to them that physical activity provided a useful reinforcement. Both Blinder et al (1970) and Brady and Rieger (1975) allowed patients a six hour pass from the ward if their weight was at least .25kg more than the previous morning. Failure to make this gain involved restriction to the ward or in some cases the patient's room. Perkin and Surtees (1976) similarly allowed two hours ward leave for .5kg gained. Other reinforcers used have included access to a shower, to mail, books, visitors and television (Geller, 1975; Poole et al, 1978; Stunkard & Mahoney, 1976). Brady & Rieger (1975) recommended that if a patient failed to gain weight over three or four days then more powerful reinforcers than those originally selected needed to be sought. Blue (1979) described the use of punishment with a patient whose vomiting behaviour had proved resistant to reinforcement and whose life was in danger. The patient later stated that it was the punishment, five lashes with a wooden switch administered by her mother after each vomiting or temper tantrum incident, that made her change her behaviour. The importance of determining reinforcers for each patient individually was stressed by Poole et al (1978) and Eckert et al (1979) suggested that the lack of individualized reinforcement may have been instrumental in the absence of significant differences found between their behaviour modification programme and a ward-milieu-only programme.

It has been suggested that often other unspecified reinforcers are operative and can sometimes interfere with treatment. Brady and Rieger (1975) see that as very likely in hospital settings. For example the 'bed rest' employed by Dally and Sargant (1966) or coercive tube feeding as described by Meyer and Otte (1970) may be classed as negative reinforcers since these unpleasant procedures were removed when appropriate eating and weight gain occurred. In a study to try and isolate some of these unintentional reinforcers Agras and Werne (1977) found that weight gain continued during the reversal period of a three stage programme which involved baseline observations, reinforcement, and reversal to a baseline period. The reinforcement involved praise, pleasurable activities and outings. Bhanji and Thompson (1974) had also found that weight gain continued in a reversal

period and suggested several possible explanations: that the reversal period was too late and/or too short, that earlier intermittent reinforcement was responsible, that the prospect of leaving hospital was involved or that there were other unknown intrinsic factors. When Agras and Werne (1977) then controlled for hospital discharge by contracting with the patient for a set period of hospitalization, weight gain diminished during the reversal period, suggesting that achieving release from hospital could well be an important reinforcement in itself. They also found that informational feedback on calorie intake and on weight progress were important to weight gain; when this was removed patients ceased to gain weight either with or without reinforcement. Finally they found the size of meal served was influential, the larger the meal the more the patient consumed.

Reinforcers selected or unintentionally used by behavioural therapists then have included both positive reinforcement such as praise or ward passes and negative reinforcement such as, for example, chlorpromazine reduction in a case of Blinder et al's (1970). The use of punishment, such as beating has also been reported (Blue, 1979). A number of these reinforcers relate to the curtailment of personal freedom and autonomy. The use of punishment is recommended only in extreme circumstances, which Blue perceived as appropriate for his case. Since he reported however that the patient had a poor self-image and that the mother was perceived as overly dominant in the family, the punishment may well have reinforced less desirable behaviours within the family.

When commenting on the selection of reinforcers in operant programmes, an important claim has been made by Geller et al (1978) that operant conditioning minimizes unpleasantness and conflict, avoids hazardous medication and forced-feeding regimes and helps staff to relate favourably to the patient. However, certain issues concerning reinforcement need to be addressed. Adequate washing facilities, permission to have visitors, watch television, have access to books or leave the ward seem to be regarded by behaviourists as positive reinforcers. The withdrawal of these freedoms, however, may also be regarded as negative reinforcement if they are

classed as normal activities in general or defined as such by the individual. There are likely to be differences between what the patient and other observers might define as normal freedom and what the hospital and therapist determine as such. Thus the boundaries between positive reinforcement, which Arkin et al (1976) and Kazdin (1980) saw as preferable, and negative reinforcement may be vague. The boundaries between negative reinforcement and punishment are also uncertain when reinforcers such as isolation or compulsory bed-rest are involved. Since anorexia nervosa is a dangerous problem it would seen appropriate to use negative reinforcement and, in extreme circumstances, punishment if eating behaviour fails to respond to positive procedures, but researchers often seem unclear as to the type of reinforcement they are employing and, as Bemis (1978) stated, the ethical dilemma is particularly great if prolonged isolation and deprivation of normal rights is part of an enforced treatment programme. It could also be suggested that these aspects impinge on issues of personal freedom, autonomy and responsibility, factors that in themselves might be central to the disorder.

The manner in which improvement in weight gain is measured has also varied in the studies. Most programmes have measured weight daily (e.g. Brady & Rieger, 1975; Perkin & Surtees, 1976; Poole, 1978). Agras and Werne (1977), in support of this, suggested that daily weighing encourages a steady increase, whereas a five-day programme, for instance, may encourage a pattern of intermittent starving and gorgeing, common in anorexia. Eckert et al (1979) considered that their five-day weighing programme might also have contributed to the lack of significant difference between their behaviour modification programme and a ward-milieu-only programme. Blinder et al (1970) found that setting a longer-term weight target, 3kg followed by a reward of freedom of movement in and around the hospital and a further 5kg in order to be discharged from hospital, resulted in weight gain considerably quicker than with their other cases on a daily programme. Geller (1975), however, warned that some patients may respond to the setting of a weight for discharge by gorging themselves which occasionally may cause dangerous gastric dilation. An important point

regarding assessment of weight gain was made by Perkin and Surtees (1976) in suggesting that it should be measured cumulatively. Before they instituted this, a patient who was allowed a ward pass on days when she had gained .5kg over the previous day achieved this and was awarded the pass on four days out of 10, but gained only .1kg over the whole 10 day period.

Several people, such as Bruch (1974) and Feinstein (1974) have criticized operant conditioning programmes for concentrating solely on weight gain. However, weight gain has been claimed by many behaviourists to lead directly to improved psychological functioning. Brady and Rieger (1975) reported patients, with some exceptions, to be less defensive, more open and more accessible to psychotherapy after weight gain. Blinder et al (1970) also reported improved Ward and personal relationships while Steele (1976) noted increased psychological stability, a better integration of actions and thoughts and a decreased level of hyperactivity. Stunkard and Mahoney (1976) found heightened feelings of well-being and Geller (1975) an increased ability to express feelings.

In condemning an emphasis solely on weight gain, Feinstein (1974) described two cases previously treated with behaviour modification. He considered the emphasis on food-intake had contributed to their use of food as an expression of pathological object relationships. Blinder et al (1970) considered that weight gain can be dissociated from improvements in other areas and Kazdin and Hersen (1980) stated that it was important for therapists not to focus on the first behaviour that came to hand, a complete assessment of behaviour being required. Bemis (1978) also emphasized the importance of attending to all the emotional and behavioural problems associated with anorexia nervosa in treatment.

The treatment procedures actually utilized by behaviour therapists seem to have accentuated their difficulties in this area of undue emphasis on weight gain. Baseline studies are usually conducted in hospital settings and with eating behaviour being the most obviously inappropriate, it is not surprising that therapists have concentrated on achieving weight gain, particularly if a sense of emergency

exists. Inappropriate behaviours that might be more evident in the home environment are seemingly neglected. This set of circumstances may also serve to explain the difficulty evident in generalizing behaviour established in hospital to the post-hospital setting, commented on by Poole et al (1978). Kazdin and Hersen (1980) also commented that research has infrequently examined whether changes in one setting transfer to another and that few studies of behavioural methods have considered the long-term effects of treatment. Behaviours achieved in hospital settings may not be the most important for long-term placement in the community (Kazdin 1977).

Other behavioural methods. Although the majority of reports of behavioural treatment for anorexia nervosa involve operant conditioning, systematic desensitization also features, as to a lesser extent do aversion therapy, assertion training and behaviourally oriented family work.

Hallsten (1965), Lang (1965) and Schnurer, Rubin and Roy (1973) used desensitization to modify anorexic behaviour. Hallsten (1965) paired graded scenes of eating at home with relaxation and the weight of the 12 year old girl involved rose from 26kg to 35kg. Lang (1965) recorded the case of a 23 year old nurse who had lost 9kg weight. He used desensitization to reduce anxiety produced by social situations which resulted in an inability to eat. He also applied assertive training to aid her in interaction with her mother and other family members. The attempts to counter condition anxiety over eating failed. Bhanji and Thompson (1974), however, have suggested that the case was not one of true anorexia nervosa since eating difficulties were confined to certain situations. Schnurer et al (1973) successfully applied desensitization to their patient but suggested that this method was indicated only where the anorexia was a phobic reaction.

Williams (1976) attempted to use a range of behavioural techniques to alter various behaviours associated with anorexia nervosa. His rationale for this was that a computer search of the literature had failed to identify any individual behavioural approach applicable to the whole

spectrum of problems involved in the cases. Working with six patients he applied desensitization to fears of weight gain, eating, social fears and disapproval of significant others; aversion therapy to pleasure in being morbidly thin and abnormal eating behaviour; an operant programme with a points system to increase various desired behaviours; self-monitoring; thought stopping; assertive training and miscellaneous techniques (sic) to help with associated sexual problems. In addition he tried to modify environmental factors that were providing inappropriate reinforcement by requesting that those connected with the subjects desist from making any further comment on the patient's eating or weight. None of his patients gained weight over a six month period and changes in attitude were minimal. Attempts to change the behaviour of the significant others were also unsuccessful. He postulated that the failure was due to the secondary gains patients made from being anorexic and identified these as attention from significant others and relief from the responsibilities of adult sexuality. Secondary gains, in relation to staff attention, could well have been operative in such a comprehensive treatment programme also.

Perkin and Surtees (1976) gave some emphasis to the need for working with families, criticizing the fact that there was often insufficient attention to social and environmental elements. They saw this as often the reason why weight gain had not been maintained after behavioural treatment programmes. In addition to an operant programme for weight gain, they recommended both working with the family and increasing the anorexic's capacity to cope with stressful situations. Reporting on one case studied, they described family interviews where parents were requested to avoid focusing attention on eating or weight gain. With the patient they worked towards modifying a poor self-image and helped her to set more realistic goals, as well as providing assertive training to help her assert herself and express her feelings. Results showed an improvement in self-esteem and a more realistic self-image. Weight gain was maintained.

The behaviourist therapeutic relationship. Kazdin and Hersen (1980) have stressed the importance of the therapist/client relationship in behaviour therapy, while acknowledging that this aspect of behavioural treatment has often been

under-emphasized. Under-emphasis probably arose from a need to reject the centrality of the therapeutic relationship as described in psychodynamic theory. Both Arkin et al (1976) and Geller (1975) in fact saw the therapeutic relationship as an area of overlap between the two approaches.

The importance of co-operation between therapist and client is noted in the literature on anorexia nervosa. Bhanji and Thompson (1974) stressed the vital necessity of securing the co-operation of both the client and her parents. Full discussion with them of the programme and any changes to it should always take place. Agras and Werne (1977) stated that the establishment of a staff/patient alliance was the first therapeutic task and Steele (1976) commented on the importance of a mutually agreed programme of weight gain and privileges. Agras and Werne (1977) pointed out the need to stress to patients during the initial observation stage the voluntary contractual nature of the programme. The target weight selected, for instance, was usually below the average weight for height since this was negotiated between therapist and patient and patients tended to prefer a lower weight. Poole et al (1978) also recommended that the patient be involved in the choice of target weight.

The extent to which anorexics should be allowed to choose their diet or organize their own eating routine is also discussed in the literature and relates to issues of power and control between therapist and client. Geller (1975) stated that his patients had a high degree of autonomy within the framework of the reward system. Although there was no choice as to the food ordered, the patient could eat whatever she wished in addition from the Ward kitchen. Brady and Rieger (1975) counselled against allowing patients to consult with a dietician or to prepare special meals, since this only encourages over-involvement in eating issues. Poole et al (1978) described a system in which a fridge in the patient's room was stocked with foods of her choice and high calorie food was also delivered at regular intervals. They suggested that this not only made food easily accessible but also enhanced self-control. Agras and Werne (1977) allowed patients to select the foods they ate, but stated that they

had to take in 5000 calories a day divided among five meals.

The extent to which the anorexic does not re-establish control over her own functioning may account for the difficulty in generalizing changed behaviour learned in the hospital to the post-hospital setting. This is commented on by several writers, for example Agras and Werne (1977) and Poole et al (1978). Kazdin and Hersen (1980) stated that effective strategies for ensuring maintenance and durability of therapeutic gains outside of treatment and educational settings had yet to be devised. Perkin and Surtees (1976) suggested a gradual relaxing of control as weight increased during the hospitalization period to aid the transfer. Poole et al (1978) established a minimum weight below which the patient contracted to be readmitted. Outpatient appointments were made at irregular intervals and patients notified only the day before in order to prevent the establishment of a starving and gorging pattern.

The frequent application of operant techniques rather then desensitization procedures may also be indicative of control issues in the therapist/client relationship. Garfinkel et al (1977) found that a comparison of a group of anorexics receiving operant conditioning with a group receiving a variety of non-behavioural treatments showed the group receiving operant conditioning to be younger, younger at the onset of the anorexia and to weigh less than the group which received other types of treatment. It might be postulated that therapists are more comfortable in establishing external controls on the behaviour of younger patients and on those in whom weight loss is more serious. Ethical issues related to patient co-operation in treatment are likely to be problematic whatever the treatment mode and, as Arkin et al (1976) pointed out, all professionals exercise varying degrees of control over people seeking help. These dilemmas need perhaps to be made more explicit, however, in the description and assessment of behavioural treatments.

Combining treatments. Behaviour modification has been recommended in combination with other treatment approaches (Van Buskirk, 1977). These have included drug treatment (e.g. Stunkard & Mahoney, 1976), family therapy (e.g. Eckert

et al, 1979) and individual psychotherapy (e.g. Steele, 1976).

The frequency of combining behavioural treatment with drug therapy was pointed out by Eckert et al (1979). Kazdin and Hersen (1980) recommended this combination for some disorders. A scheme combining drug treatment with behavioural techniques was applied by Stunkard and Mahoney (1976) using chlopromazine. One patient not given the drug initially did not gain weight on the behavioural programme until it was administered. Blinder et al (1970) applied behavioural techniques to patients who were already receiving pharmacological treatment. Bhanji and Thompson (1974) found that there was a tendency for good outcome to correlate negatively with the administration of phenothiazines, while Brady and Rieger (1975) found no clear relationship between drugs prescribed in hospital and weight gain.

As well as combinations of particular techniques, some consideration is also given to treatment combinations with regard to settings. Many writers have regarded treatment as involving two phases; the first to increase weight usually occurring in a hospital setting, the second generalizing new behaviours into the home environment (e.g. Eckert et al, 1979; Perkin and Surtees, 1976; Pertschuk, 1977; Steele, 1976; Stunkard & Mahoney, 1976; Van Buskirk, 1977). Pertschuk (1977) noted that 12 of his 27 patients needed rehospitalization later and he suggested that improvements made outside the hospital were more likely to endure. Hsu (1980) pointed out that the initial phase of treatment was relatively simple and usually successful whatever the method, but that generalizing this to long-term improvement is more difficult to obtain. This underlines the importance of outpatient treatment after hospitalization, a point stressed by Van Buskirk (1977), who noted negative results in programmes that did not include outpatient therapy following in-patient experiences.

Several writers have suggested the use of therapy with the family as a follow-up treatment (Eckert et al, 1979; Poole et al, 1978; Steele, 1976). Brady and Rieger (1975) recommended behaviourally oriented family work to deal with issues of individual independence and autonomy. Geller et al (1978) underlined the need for a functional analysis

of the anorexic's family and social environment to determine environmental factors and then family therapy to modify them. They used a skills development approach including feedback and role play. Family therapy, as it is employed within the behaviour modification approach, is often aimed at altering people's attention to the eating behaviour which has been seen as maintaining the problem (Poole et al, 1978; Geller et al, 1978). Williams (1976) found this aspect of his comprehensive treatment programe failed; reduced overt attention to eating being replaced by covert attention which helped to maintain the disturbed eating behaviour. Whipple and Manning (1978) suggested that a family could reverse any gain achieved in hospital if it was not included in the treatment programme as a whole and this may have contributed to the failure of William's programme.

Individual non-behavioural psychotherapy has also been recommended in some situations. Eckert et al (1979) employed re-educative psychotherapy focusing on interaction, whilst Geller (1975) used psychotherapy to explore underlying psychological problems. Steele (1976) felt that a psychodynamic approach, combined with activity therapies and assertiveness training, increased insight and self-expression. Individual psychotherapy, unlike family work, seems more likely to be commenced at the same time as behaviour modification treatments (Geller, 1975; Whipple & Manning, 1978).

As Eckert et al (1979) stated, the combination of treatment procedures makes it difficult to identify any independent successful factor. Agras and Werne (1977) suggested that, given the apparent success of widely differing approaches, it is possible that there are therapeutic procedures common to each and that variation in results is caused by the unsystematic application of these. Pertschuk (1977) noted that patients were referred to specialists in their own geographic area after in-patient treatment had finished, leading to considerable variety in the techniques used. This kind of circumstance has rendered assessment of outcomes difficult. Bruch (1978) pointed out that reports of behaviour modification used in conjunction with family therapy or individual psychotherapy describe the behaviour modification in great

detail but provide little information about the other treatment approaches. This is true, for example of the studies by Agras and Werne (1977), Brady and Rieger (1975), Eckert et al (1979), Pertschuk (1977), Steele (1976) and Whipple and Manning (1978).

Treatment Outcomes With Behaviour Therapy

The limitations already suggested about outcome studies in this field in general apply on the whole to the behaviour therapy approach as well. In assessing the efficacy of behavioural treatment programmes, it is noted that most studies involve a follow-up period of less than four years, and that most studies have small samples with inadequate research designs. Bemis (1978) criticized both of these factors stating that inadequate follow-up and the failure in most studies to utilize an A-B-A-B design made it difficult for results to be regarded as meaningful. It is interesting to note that virtually all studies involving a single case report relatively successful outcomes. This could be to do with intensified treatment attention, individually specific outcome criteria, more potential for comprehensive assessment and follow-up considerations, or maybe other more subtle reasons. Overall, the mode of follow-up for many studies, often by telephone and/or letter, represents a major limitation of studies reported within this treatment framework and, as well, the outcome criteria, beyond weight gain, are not always well defined. Although weight gain is inevitably the primary target of treatment and of outcome assessment, follow-up studies also usually try and assess elements of emotional and social adjustment, by looking at such things as vocational functioning, familial adjustment and peer relationships.

A number of studies have treated and reported on individual cases. Hallsten (1965), Lang (1965), Schnurer et al (1973) and Bachrach et al (1965) all treated individual cases. Five months after the cessation of treatment, Hallsten's case had maintained normal eating habits and social and familial adjustment were regarded as good, but weight at follow-up was not recorded. Six months after discharge, the subject described by Schnurer et al (1973) had increased her weight to 47.5kg and had maintained improvement in

emotional and social adjustment. Lang's case (1965), one year after treatment, had continued to improve with regard to the target behaviours (anxiety and eating) but still experienced difficulties in relationships with the opposite sex. She had regained most of the weight originally lost. At 18 months after treatment, Bachrach et al's (1975) case seemed well adjusted socially but weighed only 33 kg. Considering the protracted nature of her illness and its resistance to previous treatment this is perhaps not surprising.

Others have also worked with and provided outcome assessments on single cases. Geller (1975) treated one such subject. At one year follow-up she was functioning well socially and was of appropriate weight (48kg). Perkin and Surtees (1976) reported both appropriate weight and social adjustment for their single subject at 18 months after hospital discharge. Blue's (1979) case was reported to be of normal weight and to be successfully adjusted at school and in the family approximately one year after discharge. Similarly, Geller et al (1978) with one patient also found appropriate weight to be maintained and social and family adjustment to be good at a five month follow-up period.

Blinder et al (1970) reported on the follow-up of three cases. One had committed suicide, the second had maintained a satisfactory weight level (60 kg) but was not socially well-adjusted 10 months after discharge, and the third, eight months after initial discharge, appeared more socially adjusted but weighed 36kg and had been rehospitalized once. The writers noted that rapid weight gain in treatment did not necessarily indicate progress in other areas.

Bhanji and Thompson (1974) used postal questionnaires to General Practitioners two to 72 months after patient discharge. Of the seven patients on whom adequate information was provided in relation to recovery, one was rated as having made a good recovery, three fair and three poor. Two cases had received treatment twice and one four times. The researchers concluded that operant techniques seemed inadequate for the long-term maintenance of normal eating

habits and weight.

Brady and Rieger (1975) followed-up 16 patients, four to 39 months after their discharge, by letters and telephone interviews with the patients, their families and/or present therapists. Five were noted as having made a good recovery, five fair and three poor. Two cases had died and there was no information provided on one other. Three had required rehospitalization, and almost all had needed continued treatment after weight restoration. Garfinkel et al (1977) provided details of 17 patients who had been treated with operant conditioning and followed-up 28 to 35 months after discharge. Ten were doing well and seven were not. Most had received a variety of other treatments after their period of hospitalization. Three had required one further hospitalization period and three required more than one. Of the five patients treated by Poole et al (1978) all were slightly below their weight at discharge and below their ideal weight for height and age three to 11 months later. Three had been re-admitted temporarily because they had fallen below a contracted limit.

Pertschuk (1977) contacted patients or family members by telephone three to 45 months after patient discharge. As a group the 27 patients had continued to gain weight, a subjective assessment of adjustment indicated 12 to be good, nine fair and six poor. Good adjustment did not mean that eating problems were resolved as only two of the 27 were of a normal weight, eating normally and thought to be functioning well overall. Twelve had been hospitalized, six for weight loss, four as a result of suicide attempts and two for depression. Of the suicidal and depressed, four had been diagnosed as such before treatment for anorexia. All of those vomiting before treatment were still doing so and 10 reported episodes of bulimia where none had reported these before treatment.

Finally, a study by Eckert et al (1979) found no significant difference in weight gain over a five week course of treatment between those treated with behaviour modification and those receiving ward-milieu-only therapy. Behaviour modification was found to be slightly more effective than ward-milieu-only treatment for those without previous outpatient treatment, although this did not amount to a

statistically significant difference.

In considering outcome in behavioural therapies, a major criticism that has frequently been made centres on the issue of symptom substitution. Bruch (1974), a psychodynamicist, claimed that many of her patients had previously been treated with behaviour modification, and that for nine she had contact with in the preceding two years the results had been damaging. She quoted three cases in detail. Suicidal thoughts and depression, self-disgust, compulsive eating and vomiting and a fear of being tricked into gaining weight were evident. Many patients, she felt, worked to eat themselves out of hospital and the very efficiency of behavioural programmes served to increase the turmoil of patients by undermining self-esteem and destroying hopes of autonomy. Bruch (1978) considered that patients needed the reassurance of a good diet which would not make them fat. Undisciplined and indulgent eating in order to gain weight regardless of the nutritional value of the food was inappropriate, she stated, in that it encouraged bulimia and self-disgust. Bemis (1978) also regarded some increases in food intake as amounting to therapist-endorsed bulimia. Arkin et al (1976), as behaviour therapists, believed that symptom substitution was only likely if the original symptom was removed suddenly without the patient having had time to develop new coping strategies. Although behaviour therapists have traditionally rejected the notion of symptom substitution (e.g. Ullmann & Krasner, 1965), Kazdin and Hersen (1980) noted tempered views among behaviourists. They did comment, however, that the side effects of any treatment programme may be desirable or undesirable and that to designate the undesirable as symptom substitution was unfair. Bemis (1978) stated that it was unnecessary to refer to symptom substitution, as treatments so far had failed with some patients to identify the conditions that maintain anorexic behaviour.

In conclusion of this section on the literature about the behavioural approach to anorexia nervosa, it may be said that behaviour therapists have tended to focus on weight loss as the most obvious behaviour to be altered, with much less attention to other aspects of the disorder, and have used

mainly operant conditioning to modify this. The apparent growing emphasis on multi-faceted treatment approaches, particularly those which emphasise a second stage of treatment after the period of hospitalization, may indicate an increased awareness of the difficulties involved in sustaining weight gain and the possibility that other aspects of the disorder may also need attention. Unfortunately, these other aspects are not only less easily identified, but also less easily measured initially and at follow-up. This makes treatment itself and research on the various effects of treatment more difficult to conduct. Behaviour therapy would appear to be useful on the whole in modifying weight levels, but the apparent nature of the syndrome leaves many unresolved questions as to the acquiring of more wide-ranging and long-term results.

Anorexia Nervosa and Family Therapy

A Brief Outline of the Theory

The emergence of family therapy as a treatment approach represents something of a paradigm shift from a linear to a systems model, which may be seen as only one aspect of a universal cultural shift to studying phenomena in their natural contexts rather than in isolation (Selvini Palazzoli, 1978). In psychiatry, this movement has seen emphasis shift first from the individual's intrapersonal functioning to an interactional model, where the mother/child relationship in particular was focused on, and then to a consideration of family functioning (Minuchin et al, 1978). For two writers considered in this study, such a shift is evident in their own thinking and contributions. Selvini Palazzoli (1979) commented on the progression in this direction in her work and stated that a major cause was her dissatisfaction with individual casework, and movement towards a family perspective is also evident in the writings of Bruch (1973, 1978). Ross (1977) has also suggested that the family emphasis has emerged as more sophisticated techniques for family intervention have been developed and a clearer picture of the disturbed interaction of families has emerged. The observation of family functioning itself is not new, but the manner of interacting with the whole family in treatment is a relatively recent notion.

Since many working in the field of family therapy were originally operating within other schools of thought, there is considerable evidence of concepts which are borrowed from other fields in their thinking and work with families. Selvini Palazzoli (1978) and Bruch (1978) for example, have employed several psychodynamic concepts and often perceive family interaction within that framework, and Minuchin et al (1978) have similarly employed behavioural concepts. However, attempts have been made to develop separate concepts and many of these are located within General Systems Theory.

In family therapy the family, in accordance with General Systems Theory, is seen as a system; a complicated living unit locked into patterns (Barker, 1981) comprising inter-related parts. The system may be activated by any one of its members or by external forces. The system is more than the sum of its parts and is also independent of its parts; it is the arrangement of the parts which is primary, not the parts themselves. Family characteristics are not decided by one family member but emerge out of dynamic interaction (Caillé, Abrahamsen, Girolami and Sorbye, 1977).

The family system is regulated by rules which maintain functioning within certain limits, termed 'homeostasis' by family therapists (Minuchin et al, 1978). This balance serves to maintain the existence of the system as a viable unit. The rules determine the routes which individual communication will take and how they will be interpreted. In addition there is an over-riding rule which governs all others, that family rules be neither recognized nor discussed (Selvini Palazzoli, 1978).

Systems on the one hand provide individuals with self-confirmation, security, predictability and the satisfaction of emotional needs. On the other hand they limit individuals and demand the sacrifice of unique characteristics. A solution to this dilemma is never totally attained (Caillé et al, 1977). In healthy-functioning families, referred to as 'open systems' (Barker, 1981), changes in the environment or in the needs of individual family members bring about changes to the family's homeostasis. In other words, the range of behaviours and patterns of communication open to

the family will adjust to incorporate new needs. Changed needs are perceived as a threat to the system and the tension which this creates in the family provides the impetus to search for a new homeostastic solution (Caillé et al, 1977).

For family therapists, when dysfunctional behaviour such as psychosomatic symptomotology is exhibited by one or more family members, this indicates that the family as a whole is having difficulty maintaining homeostasis. The system, instead of being open and flexible to change has become closed and normal channels of communication are blocked. The result is an extreme expression of the problem in one family member, the identified patient. Systems become closed when they feel threatened with disintegration. Caillé et al (1977) pointed out that all family systems can be closed at times and that this normally results in a search for a new homeostasis. Where this does not emerge, outside intervention may be necessary. If intervention concerns only the identified patient, then either this individual will be unable to sustain any change in their functioning because the unchanged family system will require that they conform to the existing pattern, or another family member is likely to develop difficulties. It is considered then that the unit of treatment must therefore be the family system.

When some of the proper channels of communication are blocked within a family, often because the messages to be passed appear too threatening to be transmitted, inappropriate channels become used. Thus, for example, a conflict which exists within the spouse dyad but which remains unrecognized and unexpressed may be routed via a child. Blocked channels may also mean that family members come to acquire or take on roles which are inappropriate in the family system; a father, for example, may adopt the role of a child in relation to his wife. In this way generation lines between family members often become blurred. Blocked communication is recognized by the fact that a pattern of communication is repeated endlessly without ever appearing to attain its purpose (Minuchin et al, 1978).

Transformation, or change in the family system is dependent on finding the correct formula and is possible because

the system never employs all the characteristics of an element and different characteristics may be used to create a new homeostasis (Selvini Palazzoli, 1978). This does not require complex, protracted therapy but rather, it is claimed, an ability on the therapist's part to seize the right moment (Selvini Palazzoli, 1978). Caillé et al, (1977) suggested that the therapist's role is to erect road blocks to the family's usual patterns of disturbed communication so that new ones may emerge. A major therapeutic goal is to help the family change the system's rules, with this not occurring through explanation or insight but through actual experience. Thus attention is given to and intervention focused on the form, not the content of therapy sessions (Aponte & Hoffman, 1973).

Several writers have stressed the particular relevance of family functioning and therapy to adolescent problems. Pincus and Dare (1978), for instance, commented on adolescents' sensitivity to parental issues, particularly sexual ones, and the importance of adolescents' learning to establish individuality without sacrificing loyalty to the family. Similarly, Hall (1975) stated that it is true of adolescent psychiatric problems in general that they benefit from an improvement in total family health.

Anorexia Nervosa as Family Dysfunction

Since individual dysfunction is perceived as an indication of problems in the family system, it is the 'anorectic family' (Minuchin et al, 1978) rather than the anorexic herself which is considered in the literature and dealt with in practice.

Certain characteristics of anorectic families have been identified within this approach which are presumed to contribute to and be a result of family dysfunction. As previously suggested, anorectic families typically present themselves as having been idyllically happy until the onset of the anorexia (Selvini Palazzoli, 1979). Bruch (1978) saw this as either a denial of the problem, which may be said to be echoed in the individual patient's denial of anorexia, or a reluctance to saying anything critical about the family perhaps being a family rule. Families have been found to be overly involved in issues connected with food (Debow,

1975; Selvini Palazzoli, 1979) and bodily functions in general (Minuchin et al, 1978). Hall (1978) found that although 22% came from disturbed family backgrounds and marital unhappiness was common, there were fewer dissolved marriages among the parents of anorexics than among the grandparents. This is somewhat surprising in view of the increased overall incidence of divorce.

Minuchin et al (1978) considered that adequate separation of the anorexic parents from their own parents did not seem to have occurred, with boundaries between the parents and their families of origin appearing weak. Selvini Palazzoli (1978) found that in nine out of 12 of her cases the grandmothers were closely involved in family interaction and appeared to have contributed to the anorexia in some way. Similarly, Conrad (1977) suggested that treatment should include promoting an appropriate emotional separation of the parents from their own parents. Generation boundaries have also been seen as weak between the anorectic parents and their children by Perlman and Bender (1975) who quoted a mother who had described her anorexic daughter as a friend and confidante.

In considering the mothers of anorexics, Peake and Borduin (1977) noted on the whole intense conflict between mothers and anorexic daughters. Providing food had become a central aspect of the mother's home-maker role, claimed Selvini Palazzoli (1979), but husbands tended to minimize the drudgery of this and emphasized their wives' economic dependency. She also found the mothers to be dissatisfied and depressed, and she noted an underlying 'homosexual' bond between them and their own mothers to whom they were still tied in a relationship involving what she referred to as slavery, guilt and hostility. Their marriages seemed to be a repetition of this relationship and the chosen daughter, the anorexic, she saw as having been unconsciously focused on to console the mother in her misery. Hall (1978), however, found no support for the psychodynamically oriented idea that it was mothers who were always likely to be the central influence in the emergence of anorexia.

Fathers were generally seen by Peake and Borduin (1977)

as being uninvolved in parenting. Selvini Palazzoli (1979) described the father of an anorexic as possessing deep passive tendencies which had led him to seek an idealized mother as a wife. This then made him ambivalent towards his own children and any attempt by him to get close to his daughter was sabotaged by his wife who offered herself as mediator.

Anorexia is seen by writers in this approach as often being indicative of difficulties in the relationship between the parents in particular. The onset of the anorexia was seen as indicating hidden conflict between husband and wife by Peake and Borduin(1977). This is seen to emerge through changes either in individual members or through external stresses to which the system as a whole could not adjust (Bruch, 1978; Perlman & Bender, 1975). Selvini Palazzoli (1979) described the relationship between husband and wife as often being sadomasochistic, with each parent in turn indirectly attacking the other by appearing the victim of the other's unkindness. It has been suggested also by Aponte and Hoffman (1978) that the parents have unfulfilled sexual needs indicated by their over-involvement with their children and that this over-involvement is a means of avoiding tensions in their own relationship.

The role of siblings in the family with an anorexic presenting problem has also been commented on in the literature. Ambivalent feelings towards the nearest-in-age sibling were noted in anorexics by Hall (1978) and Selvini Palazzoli (1979). However, parents appeared to expect the anorexic to relate well to the nearest sister (Hall, 1978). The ambivalence of anorexics may be related to the very different relationship existing between the mothers and the anorexics themselves. Selvini Palazzoli (1979) claimed that there existed an erotic relationship between the mothers and the sisters and that the sisters, unlike the anorexics, were also able to behave seductively towards the fathers. The anorexics' roles meanwhile were to be model pupils at school, living up to parental expectations. Selvini Palazzoli (1979), noting the rarity of two anorexic children at a time in one family, stated that where this did occur she had found that one was not a true anorexic but was copying the other. This suggests that the anorexia meets a need in the family system

which requires only one family member to exhibit psychosomatic symptoms.

The anorexic herself is seen as developing anorexic symptoms when she is no longer able to find any other solution to the conflict between her role in the family system and her individual needs (Caillé et al, 1977). This is likely to occur at adolescence when children's needs change quickly and they seek to develop new ways of relating both inside and outside the family (Minuchin et al, 1978).

In addition to noting the various relationships and roles, family therapists lay great emphasis on the styles of intervention which take place within families. The manner in which they communicate largely remains constant whatever the content. Characteristics of family communication found frequently in anorectic families, but which occur in every family system at times, include dynamics referred to as enmeshment, overprotection, conflict avoidance, rigidity, triangulation and denial (Minuchin et al, 1978). All of these aid the family in the maintenance of strong external boundaries and diffuse internal boundaries while avoiding any issues perceived as threatening to the family's existence.

Enmeshment has been described by Minuchin et al (1978) as an extreme form of proximity and intensity in interaction. Family members might continually speak for each other (Bruch, 1978; Zeig, 1980) and there might be enormous concern and involvement in each other's well-being, for example, with the anorexic's body appearing to belong to the whole family (Minuchin et al, 1978). Boundaries have been perceived as weak and diffuse between individuals and between subsystems, the term given to subgroups within the family system, so that individual family members have little privacy or autonomy (Liebman et al, 1974; Minuchin et al, 1978), and dyadic communication becomes quickly interrupted by a third person. Generation lines too within the family have been seen as weak (Aponte & Hoffman, 1973). The manifest concern and interest, however, seems to be linked with complete denial of the other person's individual wishes and interests (Barcai, 1971; Selvini Palazzoli, 1978). A rule seems to operate that family members cannot express wishes or needs directly (Barcai,

1971; Minuchin et al, 1978).

Overprotectiveness has been seen to be linked to enmeshment. Family members seem to show a high degree of concern for each other (Barcai, 1971; Minuchin et al, 1978) and nurturing and protective responses become constantly sought and provided by each family member. Parents thus retard the development of autonomy and competence in their children (Minuchin et al, 1978) and children put effort into discerning and meeting parent needs (Bruch, 1978). The anorexia itself may be regarded as encouraged protectiveness, since the anorexic creates a strong impression of needing to be looked after (Lawrence, 1981).

Conflict avoidance was identified as a product of enmeshment and overprotection by, among others, Aponte and Hoffman (1973,) who likened it to the 'boxers clinch' which prevents any punches being exchanged. Bruch (1978) noted the sentimentalized way in which one family discussed any topic, and Debow (1975), Barcai (1971), Peake and Borduin (1977) and Caillé et al (1977) all noted conflict avoidance dynamics. Where conflict did occur, however it was almost exclusively related to the anorexia (Bruch, 1978; Selvini Palazzoli, 1979) and never to the spouse subsystem. Minuchin et al (1978) stated that a strong religious or ethical code was often used as a rationale for conflict avoidance and Barcai (1971) also provided an example of this.

Rigidity in the family is seen to maintain the fragile status quo (Minuchin et al, 1978) and create a system highly resistant to change. Such rigidity would mean that when the children reached adolescence and changes became imperative, a dysfunctional reaction was likely to be precipitated. Barcai (1971) noted family isolation from other social groupings as a technique for avoiding change.

Triangulation is regarded in the literature as another characteristic of anorectic families. It is seen to consist of a third person becoming involved in dyadic interaction (Minuchin et al, 1978). Any family alliance which develops between two is seen by the family system as a betrayal of a third who is then quickly involved (Selvini Palazzoli, 1978). Although all family members may be involved, the triangulation is most likely to incorporate the parents and the anorexic

(Aponte & Hoffman, 1973). The child, it seems, becomes arbitrator and placater (Peake & Borduin, 1977) or becomes what Andolfi (1979) refers to as the family 'switchboard'. Selvini Palazzoli (1978) suggested that the anorexic acted as an additional spouse to both parents. Minuchin et al (1978) documented an excellent example of the maintenance of the status quo by triangulation processes where the mother pleaded, the daughter refused, the father commanded and then the mother intervened to plead again, the pattern continuing for lengthy periods and never reaching a resolution.

The family therapy perspective involves an emphasis on family functioning and the anorexia in the identified patient is seen as indicative of problems within the family system. A variety of dysfunctional dynamics of anorectic families are described in the literature which, taken as a whole, are perceived as producing the anorexic response in one family member. The dynamics involved include aspects of family relationships, attitudes to external factors and styles of communication. The role of treatment is to alter the pattern of relationships and communication so that the family as a whole no longer needs an anorexic member in order to sustain itself.

The Family Therapy Approach to Treatment

This approach to dealing with anorexia nervosa requires the involvement of the whole family in therapy, often referred to as conjoint family therapy, since it is seen as a family system (Minuchin et al, 1978). Indeed, often the first task of the family therapist is to convince the family that the problem does involve all of them. Most of the work reported here consisted of sessions including the whole family, although reluctance on the part of one or more family members to attend was sometimes recorded (e.g. Debow, 1975). Both Bruch (1978) and Hill (1979) have made the point that there are families who refuse family therapy because they fear the problems and difficulties that may emerge. In some circumstances the literature covered sessions involving only parts of the system (e.g. Hall, 1975), although it was still generally undertaken within the context of family therapy. Minuchin et al (1978) stated that work with a subsystem,

for instance work on the marital relationship without the involvement of the children, usually occurs later in family therapy.

On the whole, reports on the use of family therapy concern a younger age group of anorexics. This may be due to recent trends in prevalence and diagnosis, to a readiness to adopt a stance towards the family with younger children involved, to the particular approach of the therapists, or to the settings in which they function. Peake and Borduin (1977) described family treatment with two cases involving 13 year olds, Debow (1975) 14 year old twins, Barcai (1971) two cases aged 14 years and 12 years, Perlman and Bender (1975) two aged 14 and 15, Liebman, Minuchin and Baker (1974) four cases between nine and 15. The median age of the 53 subjects in the study by Minuchin et al (1978) was 14.5 years, althogh the age range was nine years to 22 years. Only Hall (1978), who seemed less involved in conjoint family therapy, reported an 'older' age group, some of whom were seen 20 years after onset. In line with the younger age group involved, the length of time between onset and treatment is usually shorter. Minuchin et al (1978) treated patients on average six months after onset.

Bruch (1978) has also commented that therapy seemed successful with younger patients who had not yet developed more serious personality problems as a result of being anorexic over a number of years. She felt that older patients with more severe personality deficiencies needed individual psychotherapy with family work as an adjunct. Hall's (1975) study which included older patients who had been anorexic for some years, would seem to reinforce Bruch's perspective. She found it more profitable to work separately with anorexics and parents rather than the total family.

Hospitalization has appeared to be brief and not at all mandatory in family therapy. In most cases, such as with Minuchin et al (1978), Debow (1975), and Hall (1975), it served to investigate the medical condition and to stabilize weight rather than to separate the anorexic from the family. Liebman et al (1974) also used this time to establish a therapeutic relationship with the anorexic. Whereas Hall, (1975) recommended hospitalization for all until a normal

weight was achieved, Barcai (1971) treated his two families on an out-patient basis only and established an agreement with the anorexic with regard to weight gain. Minuchin et al (1978) stated that they preferred not to hospitalize and only 30 were out of 53 patients. Through the course of their study they hospitalized progressively fewer patients. Liebman et al (1971) reported hospitalization as terminating seven to 14 days after the first family session which took place when medical investigations were complete. Minuchin et al (1978) reported an average of two weeks hospitalization, with the longest time being one month.

The duration of treatment seems to be less than a year, with often the anorexic symptoms disappearing considerably earlier. Hall (1978) suggested, however, that treatment last two to three years. Caillé et al (1977) reported treatment lasting eight months to a year, Minuchin et al (1978) approximately six months and Selvini Palazzoli (1978) 20 sessions maximum, originally weekly but later spaced according to family need. Selvini Palazzoli found five patients had abandoned anorexic symptoms in less than 10 sessions, four more in less than 20. Minuchin et al (1978) stated that in their cases anorexic symptoms disappeared two to eight weeks after beginning treatment. Therapy sessions were usually held at least a week apart and often were spaced wider apart. They tended to be longer than the hour usually used in individual psychotherapy. Peake and Borduin (1977) used weekly family therapy sessions while Perlman and Bender (1975) held them no more often than once a fortnight, stating that the interval provided time for new family behaviours to be assimilated. The latter also reported having a 'warm-up' session for the therapists, an open-ended session with the family lasting one to three hours, and a post-session critique for the therapists, all involving a total of three to five hours. Caillé et al (1977) also used a three phase session: a 60 to 90 minute family session, followed by a discussion about the family dynamics and strategies for changing it between therapists and observers away from the family, and finally, a phase where comments about family functioning and instructions for the time until the next appointment were conveyed to the family.

Observers operating from behind a one-way screen and co-therapists have commonly been employed in treatment. Selvini Palazzoli (1978) used observers who did not intervene in sessions but who were involved with the therapist in making strategic decisions. Co-therapy was also employed. This enabled observation, feedback, the opportunity for complementary interventions (Perlman & Bender, 1975) and therapeutic communication in front of the family about them (Aponte & Hoffman, 1973; Selvini Palazzoli, 1978). Male and female co-therapists have been regarded by Perlman and Bender (1975) as being able to provide natural linkages with family members, and could also model appropriate adult co-operative behaviour and even constructive disagreement. As well, Selvini Palazzoli (1979) saw them as being able to generate transference and counter-transference reactions which might be used in the sessions and as an aid to help therapists cope better with seductive behaviour from family members. Co-therapy would inevitably require a high degree of collaboration between therapists, yet Dare (personal communication January 1981 during Dr. C. Dare's visit to New Zealand), stressed the difficulty in establishing a good co-therapist relationship and the artificiality of presenting it as a model relationship to the family. Time spent maintaining the co-therapist relationship and the regular use of observers could perhaps be said to reduce the apparent economy of time and personnel provided with family work.

It has been suggested that in the process of family therapy other family symptoms might occur (Barcai, 1971). Bemis (1978) commented on an increase in the level of parental neurosis following the identified anorexic patient's recovery. Aponte and Hoffman (1973) noted the incidence of anxiety attacks in a father during the course of treatment and, similarly, Debow (1975) in a sibling. Conrad (1977) reported that when an anorexic recovered, her brother developed psychotic delusions that the devil in his sister had now entered his body. Barcai (1971) stated that these kinds of occurrences would be minimized by an experienced therapist, but they also seem to indicate the appropriateness of treating the whole family rather than just the anorexic.

Several researchers have found that during the course of

treatment there was usually a shift of focus to consideration of the marital relationship (e.g. Liebman et al, 1974). Perlman and Bender (1975) found that parents became more willing to examine their own interactions and conflicts after the anorexic had returned to a normal weight. The case described by Caillé et al (1977) also demonstrated this gradual shift as did the four cases discussed in detail by Minuchin et al (1978) where in three out of four cases the later stages of therapy actually involved work with the parents apart from the children. The treatment did not represent a move away from the family therapy paradigm but a choice to work with subsystems within the family in order to strengthen their role in the whole family system.

Family therapy therapeutic relationships. In accordance with the view of the family as a system which demonstrates its patterns of communication regardless of content, family therapists stress the importance of the strategies they employ during therapy in the context of their relationship to the family system, to restructure family communication. The use of observers, video cameras and transcripts of tapes has enabled individual therapeutic interventions to be discussed and their apparent effectiveness gauged. Much of the literature on the family therapy approach to anorexia nervosa includes accounts of therapy sessions to illustrate the strategies employed.

Minuchin et al (1978) stated that the therapist's first task was to 'join' the family, recognizing its strengths, hierarchies and values, supporting its subsystems and individuals. At the same time the therapist, they considered, should assume leadership of the system in order to control the flow of transactions. Interventions could not be made from outside a system yet the therapist needs also to resist the system as it attempts to undermine his or her power to bring about change (Minuchin et al, 1978). A good therapist would use the family's own pathways i.e. their normal transactions and metaphors, to bring about change (Aponte & Hoffman, 1973).

The major part of the therapist's task is seen to involve restructuring of the system in order to prevent re-emergence of the symptom (Aponte & Hoffman, 1973; Liebman et al, 1974).

It is claimed that to do this, individualization has to be supported through challenging enmeshment in the anorectic family. There are many examples of this evident in the literature. Insistence on family members talking for themselves and not for each other, prevention of a third party intervening in dyadic conversations, changing of seating arrangements to strengthen subsystems are all evident in the work of Minuchin et al (1978), for example. Selvini Palazzoli (1978) temporarily encouraged a father/daughter alliance in order to restructure both the spouse dyad and the mother/daughter relationship. By stating that the behaviour of another child other than the anorexic was problematic, Caillé et al (1977) altered family structure in one case. Aponte and Hoffman (1973) suggested the 'setting up of battle lines' as a part of the restructuring so that existing conflicts might emerge.

Restructuring has also involved emphasizing generation boundaries which are often diffuse (Conrad, 1977; Liebman et al, 1974; Minuchin et al, 1978). Selvini Palazzoli (1978) stated that the anorexic's loyalty to her parents isolated her from her peers. In the case described by Caillé et al (1977), the father needed to return to the spouse dyad from the children's subsystem, and in that described by Andolfi (1979) the child needed to separate herself from the spouse subsystem.

Another strategy employed by some family therapists involves a redefinition of the problem. In work described by Andolfi (1979) and Selvini Palazzoli (1978), the anorexia was defined in positive terms to the family and cast as an attempt to help the family system. All family behaviours were defined in this way, with the positive connotation being attached to the behaviour's function rather than the behaviour itself. In this way, no one was 'to blame'. Caillé et al (1977), in the case they reported, employed both re-definition of the daughter's symptom and of the son's role in the family. Selvini Palazzoli (1978) stated that a positive connotation of all interactions enabled the therapist to retain the leadership, to demonstrate the family's involvement in a single pursuit and to remove the

patient from the central position where she was seen as the only cause of difficulty in the family. The anorexic could no longer be perceived as being in control of the system nor the system be seen as waging war against an abstract entity, the disease.

Redefinition of the problem can be linked to a strategy of proving therapist support for the status quo, so that therapists do not become perceived as a threat to family 'homeostasis'. Caillé et al (1977) stated that, according to 'homeostatic law', pushing for change would result in the re-inforcement of the operating rules, but an insistence that they should remain unchanged would actually create a need to change. Family members in this way are seen to be forced to recognize their own dissatisfaction with family functioning. The strategy represents something of a paradoxical injunction to the family system - something that is often used also with individuals in the system. Both Caillé et al (1977) and Selvini Palazzoli (1978) have recommended 'prescribing' the actual anorexic behaviour to the individual and the system. In this way a 'spontaneous' action could no longer remain spontaneous and would lose its value as an indirect communication about family problems. In order to rebel against the controlling therapist the anorexic is said to be faced with having to relinquish her symptoms.

Some therapists have used a crisis approach to begin therapy. It has been considered that by immediately confronting the family with a situation it would be unable to handle without discomfort to the members, families would be quickly forced to recognize both the involvement of the whole family in the problem and their need for help (Barcai, 1971). This approach also appeared to remove the eating problem quickly (Minuchin et al, 1978) thus demonstrating early in the treatment the usefulness of therapy (Barcai, 1971).

A family lunch session employed by Minuchin and his colleagues (1978) was used to face the family immediately with its struggle over eating, thus redefining the anorexia as a family problem (Liebman et al, 1974) and allowing it to be dealt with, whilst it was happening (Aponte & Hoffman, 1973). In some cases in the lunch period the issue of food

was deliberately focused on by the therapist in order to demonstrate the family's inability to handle the control issues; whilst in others it was ignored, underlining the existence of the more important problems in the family. The lunch session proved a turning point with regard to gaining weight, the weight of all cases apparently improving steadily subsequently (Minuchin et al, 1978).

Therapists have used both modeling and role play in their work. Minuchin et al (1978) have stressed the advantage of enacting issues instead of talking about them. Liebman et al (1974), for example, were involved in 'joining' the anorexic by eating lunch with her in hospital. Aponte and Hoffman (1973) highlighted the therapist's eating behaviour as a strategy during the family lunch session when therapist eating behaviour was synchronized with that of the anorexic. The therapist modeled appropriate 'head of the household' behaviour in Barcai's (1971) account in order to strengthen the parental subsystem, and Selvini Palazzoli (1978) recorded the use of the management of co-therapist disagreements as a model for parents. By placing the anorexic on cushions high above the rest of her family the therapist in Andolfi's (1979) account gave concrete representation of her role in the family, as did Minuchin et al (1978) when the anorexic was made to throw her food on the floor to represent her triumph over her parents in the struggle to get her to eat.

Lastly, therapists often set family tasks to be performed between therapy sessions. Some used have been paradoxical in nature so that the family were involved in breaking their own rules and some were aimed at restructuring the system or re-defining the problem. Walrond-Skinner (1977) stated that it was not the task itself that was important but the catalytic function it served for restructuring, so whether the task was successfully performed or not was not of prime importance. Tasks have been used to strengthen spouse subsystems (Caillé et al, 1977; Aponte & Hoffman, 1973; Perlman & Bender, 1975) or sibling subsystems (Walrond Skinner, 1977); to clarify a parent/child relationship (Selvini Palazzoli, 1978); to differentiate individuals (Aponte & Hoffman, 1973); and to redefine the meaning of food (Zeig, 1980). Within this

strategic consideration, Selvinia Palazzoli (1978) noted the cultural power of rituals, describing their application to her treatment. A ritual she defined as an action accompanied by verbal formulae, involving the whole family in a regular sequence of steps at the right time in the right place. The aim was to produce a new normative system. The time lapse between sessions allowed the task or the 'ritual' to be integrated into family functioning. (Perlman & Bander 1975; Selvini Palazzoli, 1978).

The issue of control in the therapeutic relationship has consistently emerged throughout the literature and can be seen to be an important concern when considering the family therapy approach. The family leadership role sought by the therapist clearly seeks power which has been used to reorganize family functioning, often seemingly outside of the family's awareness. To join any previously formed group and wrest its leadership... is indeed a powerful action, and to join a family without becoming caught in its patterns of communication requires considerable skill. Hill (1979) in recognizing that family therapy could not be a universal panacea commented on the level of confidence and flexibility required in a family therapist. Certainly in reading accounts of treatment, the personalities of the therapists are strongly evident and their ability to challenge and support, alter family meanings, and make and break alliances, conveys the impression of considerable power.

Family therapists often seem to use their power flexibly, supporting first one family member then another. In these circumstances family members, including the anorexic seem to perceive this as constructive use of power which promotes individual autonomy and power within the family. Rather than being a force to be resisted, the therapist's control here may represent an attribute to be copied by anorexic and family. Walrond-Skinner (1977) has claimed, however, that power is no more an issue in family therapy than in any other therapeutic relationship. She has suggested in fact that the balance of control is more equal between a family and a therapist, where family alignments could be used to block the therapist's maneuvers, more so than in individual treatment. She suggested that all therapy involved a paradox; individuals come to be directed by the therapist so that they

are better able to resist being directed by conflict from within or by external pressures. The matter of the family therapist's power and control is not specifically raised in the literature on anorexia nervosa and since the family therapy approach is relatively new, especially in relation to this disorder, there have been few critical reviews to comment on this issue.

Combining treatments. Family therapists appear to adopt an eclectic approach to treatment, in that they draw considerably from other approaches. However, the concepts and techniques reported in the literature which they have adopted from other approaches seem to be reformulated so that they are not at variance with the family systems paradigm.

Several studies have used a combination of treatment procedures usually involving family therapy and operant conditioning. Minuchin et al (1978) stated, however, that behaviour modification was only a small part of their programme. Walrond-Skinner (1977) drawing on a similarly behavioural perspective stressed that family therapists aimed at improving reciprocal reinforcement patterns in a family, not to designate one family member as a therapist. Perlman and Bender (1975) pointed to the similarities between behavioural approaches and family therapy; both they claimed being action not insight therapies, having specific treatment goals and being directive and criterion-oriented, where therapists employed an active role in restructuring the environment.

Family therapists when working with the individual anorexic in a hospital setting, have used operant conditioning for objectives of weight gain (e.g. Liebman et al, 1974; Minuchin et al, 1978; Peake & Borduin, 1977). In the study by Liebman et al, patients' activities were contingent on weight gain and they were not allowed out of bed unless their weight was .25kg heavier than the previous day. Minuchin et al (1978) adopted a similar stance and likened the system to a cheque account; weight gain represented energy in hand, activity represented energy expenditure. Younger children had firmly controlled programmes to reinforce adult authority, older anorexics were allowed some room to negotiate in order to promote autonomy.

Operant conditioning has also been used on an out-patient basis, where it became a family task (e.g. Liebman et al, 1974). Perlman and Bender (1975) described a programme where the mother and father were each given separate tasks concerning the issue of weight gain. In Liebman et al's (1974) report the whole family was involved; if the anorexic did not gain weight a family member was obliged to keep her company when she was not allowed out. The family joined together in bringing about weight gain.

Although adopting essentially a family therapy systems approach, Peake and Borduin (1977) recommended a combination of behavioural and analytical approaches. They felt that the analytic approach would provide an understanding of the underlying dynamics in the individual anorexic, the behavioural approach could quickly remedy the physical symptoms and the systems approach could alter the family functioning, without which individual change was likely to be short-lived. Hall (1975) also favoured a combination of these three, with long-term individual psychotherapy being a feature. It must be remembered that her sample involved older patients for whom onset had occurred at a much earlier date. A psychodynamic approach in therapists' understandings of family interaction is evident in much of the writing on family therapy, in particular the work of Selvini Palazzoli (1978, 1979). This understanding is not usually conveyed to the families however, but used to aid the therapist in understanding what restructuring needs to take place and how to obtain it.

Treatment Outcomes in Family Therapy

It has been suggested by both Bemis (1978) and Van Buskirk (1977) that a family therapy approach to anorexia nervosa was too new to enable adequate comparisons of outcomes with other treatment approaches. Even now this is still to a certain extent the case, for many studies have only been able to incorporate and report very short-term follow-up periods. Also, it is important to note that records of the outcome of family therapy have concentrated in the main on the individual anorexic, rather than on the total family. Assessment of family functioning has been only broadly described, noted in passing or at times ignored. This circumstance is likely to

be also to do with the relative newness of the treatment approach and a primary concern to recognize the dynamics and develop the concepts involved before being able to translate these into outcome indices. If the theory of family therapy is to be adopted in treatment however, consideration of outcome must involve an attempt to assess the family as a whole, despite the inevitable complexities involved.

Peake and Borduin (1977) reported outcome assessment at the end of treatment for their two cases. One case was at a suitable weight and family functioning was subjectively reported to be improved. The weight of the other had stabilized at 38.6kg and was not increasing. Assessment of these criteria were undertaken at treatment completion and no follow-up results were available. The case described by Aponte and Hoffman (1973) was recorded as having reached a normal weight and having obtained a boyfriend six months after treatment ended. Again the follow-up assessment occurred too soon after the termination of treatment to indicate any long-term effects.

Caillé et al (1977) contacted their single case by telephone three months after termination. Improvement in all aspects was reported by the mother, but serious questions surround the follow-up time, the method of gaining information, and the source. Ten months after treatment ended, Perlman and Bender (1975) contacted their two cases. The designated patients were of normal weight, functioning well in their family and at school and work with their peers. No other problems in the family were reported. The writers do not state, however, the method of obtaining or the source of their assessment information. Zeig (1980) recording Erickson's involvement with a single case, reported that the therapist's view was that the girl was in the final stages of resolving social difficulties four years after entering treatment, which had been intermittent. The cases treated by Debow (1975) were still in treatment at the time of his publication. He recorded persisting difficulties regarding body image and eating. Selvini Palazzoli (1978) provided no details of follow-up, the cases being too recent in her view to merit it. However, she recorded three treatment

failures out of her 12 family therapy cases, which she accorded to therapist errors - a confession infrequently found in the field of psychotherapy.

The 53 cases treated by Minuchin et al (1978) provide the only comprehensive record of a large sample assessed some time after treatment. Cases were followed-up 18 months to seven years after treatment ended. The period involved was more than two years for 80% however. An assessment of weight and eating habits found 86% to have recovered, 4% to be fair and 10% either unimproved or relapsed. The figures were identical for psychological functioning.

The results of family therapy treatment in general with regard to anorexia nervosa are yet to be adequately determined, with the study by Minuchin et al (1978) seeming to provide the only reasonably reliable assessment of treatment outcomes and follow-up. It is difficult therefore to say anything substantive about the effectiveness of family therapy with regard to anorexia nervosa. The promise conveyed in the general literature is encouraging but empirical data on relevant objectives are limited. The potential would appear to be favourable but this is likely to be accentuated in that those within the approach tend to focus on a younger age group with a shorter period between onset of anorexia symptoms and treatment. Both of these factors seem indicative of a more positive prognosis.

Summary and Foundations for the Empirical Study

The literature on anorexia nervosa and its treatment is extensive. This review has found it to be a complex psychosomatic syndrome, affecting mainly young women and consisting of a number of characteristics, the relationships between which are uncertain. It is usually identified physically by the extent of weight loss, amenorrhea, hyperactivity, and, for some, bulimia and vomiting. Psychological symptoms include a steadfast determination to be thin by restricting eating, a distorted body image, poor self-concept and a sense of ineffectiveness. Several relatively distinctive family features are also apparent. On the whole, families appear to be middle-class and ambitious. Various patterns of interaction have been noted, but it is unclear which of these is

related to the anorexia. Although difficult to establish the figures, anorexia nervosa appears to be increasing in incidence but for reasons which are unclear. The success rate of treatment has not been good, with what outcome studies there are having suffered from a number of weaknesses which render the results of individual studies questionable and any comparison of studies almost impossible. Equally, there is considerable uncertainty about prognostic factors, but a younger age of onset, shorter duration of the illness and to a lesser extent absence of bulimia and vomiting, would appear to indicate a better prognosis.

The psychodynamic approach to anorexia nervosa explains the problem as an inappropriate attempt to achieve intrapersonal balance, the origins of which lie in early experience. The psychosexual stance perceives it as resulting from fixation at an early stage of development which has resulted in a confusion of eating with sexual and aggressive impulses. Also it is represented as a refusal to enter into adult sexual functioning. The ego psychological stance explains anorexia nervosa in terms of inadequately formed ego boundaries which need strengthening. Psychodynamic treatment issues centre on how classically interpretive therapy should be and the appropriate nature of the therapist/client relationship, where concerns about control appear to be evident. The process of achieving weight gain seems problematic in this approach, and any combination of psychodynamic treatment with approaches other than pharmacotherapy appears rare. There is a growing interest in present family involvement in the syndrome among psychodynamicists and an indication that other family members may also require treatment. The results of treatment are often very unclear, since the emphasis in accounts of treatment is on the concepts involved rather more than on results.

Behaviour therapy explains anorexia nervosa in terms of maladaptive learned behaviour. Although families are recognized as the locus of learning there is surprisingly little emphasis placed on reinforcement patterns from this source. The family's influence is largely recognized by therapists in this framework by an insistence on removing

the anorexic from their care. The emphasis in treatment is on weight gain with psychological functioning largely being presumed to improve as weight increases. Most studies employ operant techniques in hospital settings, although some studies report the use of desensitization. A variety of formats have been used in operant programmes, the most common reinforcer being activity, but with a wide variety of alternatives. Unintentional reinforcers have also been claimed to operate. On the whole, weight gain, rather than food intake has been preferred as the target behaviour, with treatment programmes usually involving baseline data collected in the hospital setting. Other aspects of the disorder seem to be focused on less. More recently, however, recommendations have been made towards generalizing eating behaviour to the normal setting outside the hospital and to dealing with other aspects of the syndrome. Therapist/client involvement seems to raise issues as to the appropriate extent of therapeutic control. Treatment appears to be relatively successful on a short-term basis but longer-term consideration reveals less positive effects.

Family therapy explains anorexia nervosa as a problem of the family system and emphasis in description, understanding and treatment is on the family rather than the individual anorexic. Individual family member characteristics are important, not with a view to tracing the source of the anorexia but rather to explore the complex dynamics of family interaction. The anorexic is perceived as occupying a powerful position in the family, in that her problem enables the whole family to avoid other issues of deep concern to them. The style of family interaction is also seen as important and patterns of enmeshment, overprotectiveness, conflict avoidance and rigidity are identified. Treatment involves restructuring family interaction so that other more appropriate communication patterns become established and underlying conflicts emerge. To do this therapists join the family system and orchestrate it from within. Family therapists often use behavioural methods to bring about weight gain and employ some psychodynamic concepts to explain present family functioning. Consideration of outcomes in family therapy is problematic because

it is a relatively new approach and long-term follow-up has not been possible. The satisfactory application of concepts of family functioning to assessment has yet to occur.

Major differences in understanding, explanation and treatment of anorexia nervosa seem evident. Perceptions of the disorder tend to be selective with the different approaches emphasising quite different aspects. Confusion surrounding the features of the syndrome, reports of treatment outcome and prognostic features all render it difficult to make any judgement as to the most appropriate perceptions of causative factors. As prevalence appears to be increasing it becomes all the more necessary to determine what these might be. The research question in this study, therefore, focuses on a return to a consideration of the disorder from the individual anorexic's viewpoint, without the largely pre-set filters provided by existing treatment theories and settings. The aim is to explore the anorexics' individual experiences of the disorder and perceptions of its characteristics, origins and dynamics; its part in their relationships, acitivities and attitudes regarding treatment; then to relate these to questions of treatment theories and methods. This, then, is the foundation on which the ensuing empirical study is based.

CHAPTER THREE

M E T H O D O L O G Y

This Chapter sets out the research approach used in this study. Firstly, the research questions, as originally formulated at the end of Chapter One, are restated, then the approach utilized for seeking answers to these is discussed. Issues concerning the selection of the subjects are indicated, the sample itself is identified and sources of information are described, and, finally, procedures employed in the collection and analysis of the data are outlined.

The Research Approach

The review of the literature presented in the previous Chapter revealed that questions to do with the nature of anorexia nervosa and its causative factors remain largely unanswered and that considerable difference of opinion exists among various theoretical treatment approaches. It has proved impossible to identify consistently effective aspects of the various treatment approaches or even to state which aspects of the problem are not adequately addressed in treatment. This study therefore asks the general question 'What is it like to be an anorexic?', and through this attempts to identify possible causative factors and to relate these and other significant experiences of anorexics and those closely connected with them to various treatment approaches.

The necessity of examining closely the experiences and perceptions of anorexics and others without reliance on any pre-determined explanatory framework existing within the various major treatment models, suggested an intensive investigative method. A case study approach emphasizing a phenomenological orientation, was therefore utilized. The aim was to explore at some depth with a small group of individuals who at some stage had suffered from anorexia nervosa their experiences and perceptions of the disorder and in particular its origins, management and treatment. In addition, the experiences and perceptions of some of those who had been close to them during the period of the disorder were also to be considered.

The case study method is traditionally seen as useful

in two contexts: to make individual comparisons against general theory and, because of its flexibility, to explore the formulation of new theories (Faraday & Plummer, 1979; Neale & Liebert, 1973). Given the lack of knowledge and conflicting theories as to the likely etiology and to date the non-ascendancy of any one explanation, these features would seem particularly appropriate for studying anorexia nervosa.

Kapferer (1980) stated that case study facilitates the collection of full and rich data and Nisbet and Watt (1978) saw it as providing an opportunity for in-depth considerations which can explore fully the interactions of factors and events. The apparent complexity of the anorexia syndrome renders such in-depth examination valuable in that its wide ranging elements and the relationships between these may be more completely explored.

Faraday and Plummer (1979) have commented that most social science research is involved in a process of amputation and they stressed the value in taking a more total perspective. Nisbet and Watt (1978) stated that the value of case study is its recognition that the whole is more than a sum of its parts. An holistic approach, possible in case study work, provides an opportunity then to consider anorexia nervosa beyond the constraints that might be imposed by one treatment perspective and to focus on the disorder from an individualized perspective.

A real strength in the method lies in its recognition of the unique nature of each individual (Neale & Liebert, 1973). It enables the subjective reality - the phenomenology - of individuals to emerge (Bullivant, 1978; Elbaz, 1981; Faraday & Plummer, 1979). Dryden (1980) suggested that there is value in employing research methods outside of the dominant paradigm which elicit meanings from participants themselves rather than attempting to impose meanings on their experiences, and De Groot (1969) saw the phenomenological method as useful in counteracting premature acceptance of concepts and classifications. The actors, not the researcher, are placed at the centre of the research and are regarded as having the ability to perceive, interpret and define their own situations and to act accordingly (Kapferer, 1980). Such an approach may allow different themes from those already evident in the treatment

literature to emerge. For, once diagnostic factors have been determined according to a specific theory, there is a tendency for other factors which may be of relevance to be neglected and a narrow framework to operate.

Several researchers like Faraday and Plummer (1979) and Nisbet and Watt (1978), have recognized the importance of case study as a complement to large-scale inquiry. Schwartz and Jacobs (1979) also stressed that the interplay between the two orientations could be especially fruitful. In this way understandings employed in studies of the treatment of anorexia nervosa using larger samples, such as those by Bruch (1973), Kalucy et al, (1977) and Minuchin et al (1978) could be matched against the experiences of a small number of cases.

A case study approach also offers extensive exploratory potential. By considering intensively a small number of subjects in a framework that allows themes to emerge as the research progresses, there is a possibility that aspects of the disorder which have previously received little attention in the literature may emerge as important. These exploratory findings can then be examined further in wider research contexts.

Finally, it may be said that although the literature relating to the three treatment approaches considered often discusses concepts and procedures in considerable depth, it usually fails to convey any real impression of what it is like to be anorexic. The extensive use of material from the subjects in a case study approach enables the reader to obtain a clear perception of the issues involved (Elbaz, 1981) as well as any interpretations made about these by the writer. Additionally, practical examples can be used to illustrate ideas (Nisbet & Watt, 1978) providing a three-dimensional reality to the study.

The Subjects and Their Selection

The choice of a sample is a difficult and important issue in any research and perhaps even more so with the case study method. Given that the number of individuals will be few, generalizations will inevitably be restricted. However, themes and trends which emerge may be tested against studies

with larger samples using quantitative measures. Unless the findings and any comparisons with other such studies are to prove pointless, however, the subjects chosen for the case study research must be in some way representative of the wider field.

It was recognized that it was likely to be difficult to locate an adequate sample since anorexia nervosa is generally regarded as being a rare or at least 'hidden' complaint. In addition, issues of protecting patients' rights meant that the local hospital could not assist in providing contacts with ex-patients. However, it was found that wide-spread enquiries and informal conversations led to a number of likely contacts evolving. The impression gained, consistent with what was being suggested in the literature, was that the disorder was not as rare as might have been expected and that people in general were becoming much more aware of its existence. It was possible through these contacts to gain access to several anorexics and to determine a sample of seven individuals that was likely to be suitably representative of the disorder.

The subjects were chosen on the basis of several broad criteria. Firstly, that they werewilling and able to be involved in discussing their experiences; that they were females; not seriously anorexic at the time of the study; and had been formally diagnosed as anorexic or met the major diagnostic criteria of having had a loss of 25% or more of body weight, with an age of onset between 12 and 25 years, a determination to be thin, and had amenorrhea and indications of overactivity. Five of the seven had been formally diagnosed as anorexic. Additionally, to try and widen the scope of the sample a range of various factors such as age, age at onset of the disorder, treatment experiences and time since recovery was sought. The fact that there were seven cases finally chosen for inclusion in the study was a compromise among the number available, their contribution to the diverse range of factors sought, and what was experienced as manageable for the individual researcher within the demands of the method. The likely limitations with regard to subject selection and

representativeness will be examined later along with other potential limitations of the study.

Table I presents brief details of the subjects studied. A more descriptive comment about each will be made early in the results chapter to provide a context in which to consider the findings. The names have been altered to maintain anonymity.

TABLE I : DETAILS OF THE ANOREXIC SUBJECTS

Name	Age	Age of Onset	Main Treatment Received	Time Since Recovery	Marital Status	Present Work
Barbara	27	18	Hospitalized - Individual psychotherapy	1½ yrs.	Divorced. No chln.	Journalism.
Deborah	16	12	Outpatient - Family Therapy	Not yet recovered	Single	School Student
Elizabeth	35	22	None	9 yrs.	Married. No chln.	Social Work
Karen	18	18	None	Not yet recovered	Single	Teacher Trainee
Sarah	18	16	Hospitalized - Family Therapy and Individual psychotherapy	9 months	Single	Food Industry Work
Tania	20	17	Hospitalized - Medical treatment	2 yrs.	Single	University Student
Teresa	24	14	Hospitalized - Behaviour Modification	8 yrs.	Single	Nursing

Cases with severe anorexia at the time of the research were avoided for several reasons. First, it was felt that involvement could interfere with or hinder their treatment which might be delicately balanced. Second, as is evident in the work of Faraday and Plummer (1979) it can be difficult to restrict the boundaries between the research relationship and other types of roles (e.g. therapist) and it was decided

that this confusion would perhaps be greatest when interviewing existing severe anorexics. The writer did indeed experience some of this when interviewing one case (Karen) who had developed clear-cut and increasing anorexia symptoms during the previous nine months but who had not yet been diagnosed formally as anorexic. Third, as Denzin (1970) pointed out, subject drop-out is likely to be a difficulty in the case study approach and it was assumed that there would be more risk of this happening if the person was seriously anorexic at the time of the study. Finally, the literature suggested (e.g. Bruch, 1973) that it was likely to be very difficult to talk to grossly underweight anorexics. Indeed this was born out somewhat in the interviews with the two current anorexics in that they proved to be considerably more difficult to communicate with at any depth compared with the other subjects. They did not readily elaborate on their experiences and perceptions and the interviewer was called on to be more active within the interview.

In addition to the anorexics themselves, four mothers, three fathers, two sisters, two therapists and two teachers were interviewed. Information was also gained from two friends. A diary and a letter from the period of the anorexia were supplied by one case and another provided an autobiography written as a student assignment before she was aware that she had actually been anorexic. Table Two sets out the sources of data for each anorexic.

TABLE TWO: SOURCES OF DATA

Subject	Inter-view	Mother	Father	Sister	Thera-pist	Teach-er	Friend	Doc-um-ent
Barbara	X	X	X					X
Deborah	X	X	X	X	X	X		
Elizabeth	X							X
Karen	X	X					X	
Sarah	X	X	X	X	X	X	X	
Tania	X							
Teresa	X							

In addition to observing the anorexics during the interviews, four of them were seen in their home situation with their families, and the parents of one case who lived away from home were also visited. The choice of the other individuals involved in the study, apart from the parents, was dictated by the content of the interviews with the anorexics, this procedure following the suggestions of Schwatz and Jacobs (1979). Where individuals were mentioned as being important during the time of the anorexia, if possible they were later interviewed. In some cases this was not possible. The ex-husband of one case was not available; several sisters were not available; one entire family of origin lived overseas; and it was not possible to contact several therapists.

Data Collection

Initially, the aim was to employ a flexible and open approach in data collection as suggested by Nisbett and Watt (1978) and by Bullivant (1978). The latter writer elaborated a process of 'grounded theory' and this was in line with the kind of orientation being adopted towards data collection and analysis in this study. Bullivant (1978) saw grounded theory as being:

> in contrast to the emphasis of positivistic research on testing hypotheses derived from formal theory which has been formulated outside data... This [grounded theory] is the inductive formation of substantive, middle-range theory based (grounded) on ethnographic data. (p.243)

In this present work, all potentially significant theories and concepts were held in the background initially (Haig 1980), maintaining a very general orientation to the theory (Faraday & Plummer, 1979), especially in the early data collection contacts. Gradually there evolved a balance between theory and the individual flavour of cases.

A list of broad areas of interest was drawn up to form the initial framework for the interviews. Specific and detailed questions were not prepared since the intention was to let the interview develop from as flexible and as open a stance as possible. Three periods of interest were recognized starting from the period of the anorexia, then the period

before the anorexia and, finally, the present time. Topics which the interviewee introduced were to be pursued further as seemed appropriate and relationships between issues which they regarded as important were to be fully explored. In subsequent interviews with those other individuals identified as meaningfully involved in the anorexic's experience a similar framework was adopted, but also the topics that had emerged as especially important for the anorexic were explored with them as well.

Once a general agreement was made that the subject was prepared to be involved in the study, a time was arranged for the interview to be completed. On each occasion the interview with the anorexic herself was the first contact involving any substantive information about the case. The interviews took place in locations most convenient and suitable for the subjects - mostly at their residences - and at times when it was possible to have several hours of uninterrupted discussion (See Appendix for an example of the process with one case). Permission was obtained from each subject before any contacts with other people were initiated. Interviews were tape-recorded in order not to overlook any aspects which might later prove to be important, to allow researcher concentration on the process of the interview as well as the content thus maintaining the flow of the interviews, and to avoid researcher selectivity in the urgency of initial note-taking. Participants were initially asked if they minded a tape-recorder being used and only one person, a therapist, objected.

As the interviews progressed important issues began to be identified and explored and these were checked not only with those individuals who were closely connected with the anorexic concerned, but also with other subjects in their interviews. Faraday and Plummer (1979) stressed the importance of systematic thematic analysis as the research progressed. The theme of a real concern about present exercise levels and sporting activities emerged, for instance, with one subject and later the attitude of the family as a whole to these elements was explored as was the stance of other subjects to the same issues when they were interviewed.

The systematic collection of information from a variety

of sources and by a variety of techniques was regarded as important (Nisbet & Watt, 1978). Kazdin (1981) has also emphasized the importance of providing objective information to support anecdotal reports in a single-case experimental design, with the same likely to apply in case study work. As previously mentioned, documentary evidence was sought from all the subjects and some was made available. Hospital notes were unfortunately not available. Observation was regarded as another important source of information. In all the households visited refreshments were offered and the researcher took up the invitation as it provided the chance to observe eating behaviours and attitudes towards food. Bullivant (1978) stressed the importance of such observations as they offer the chance for providing a balance with what must be obtained through the inner view of the subject.

Observation in case study work involves an element of participation, with Bullivant (1978) referring to it as supplemented participatory observation. This involvement is important as it allows the researcher to enter the natural setting of the subject (Diesing, 1971) and to 'adopt' the perspective of the subject or subjects (Denzin, 1970). Initially the researcher introduced herself as involved in research on anorexia nervosa within the context of University work, which provided some status but identified her as a learner and as someone with an understandable curiosity about normally private matters. It was clearly impossible for the writer to be accepted as a full member of the social units under observation as these were established families. As all the parties involved negotiate the role a participant may play, there are times when researchers may be asked to play roles that they had not originally envisaged being asked to adopt. This kind of circumstance is evident in the work of Faraday and Plummer (1979), and to a certain extent it emerged in this study. On one occasion the researcher was asked if she was in a position to provide a subject with counselling help, for instance. In this case the person was given the name of a therapist to contact.

Data Analysis

As previously suggested, some analysis of the data within

the method used occurs in the actual process of data collection. It is an on-going process with issues and themes gradually being identified and explored and tentative theoretical perspectives being built up. Between interviews the tapes were reviewed and notes were made on their content and, as suggested by Nisbet and Watt (1978), topics were identified that were to be raised in subsequent interviews. A similar procedure was adopted with the observation notes and the available documents. As an example, the existing importance of food in the life of the first anorexic interviewed emerged as central. Her attitude to eating was then checked with other family members as were their own attitudes to eating explored. Other anorexics were also obviously asked about their existing eating habits and attitudes and observations were made of eating behaviour.

In case study research, the validity of data collected is usually tested by a process of triangulation. This involves data being checked against other sources of information with this taking place both during the data collection process and during the final overall analysis of data. Nisbet and Watt (1978) identified three main sources of case study information which could be triangulated: interviews, observations and documents. Diesing (1971) identified a greater number, with his seven being: informant statements, documents, observation, tests and counts, informants' opinions, actions by the participant-observer to test an interpretation, and challenge by the participant-observer to other participants. He also stated, however, that three or perhaps four of these should be sufficient and that their choice must be appropriate to the subject being studied.

Most of the cross-checking in this study used the various participants' comments about themselves, about each other, and the researcher's own observations. In some cases documentation was also available. Participants were asked their opinion when this seemed appropriate and occasionally the researcher was able to test an idea by her actions or by challenging a participant. For instance, it was possible to challenge one subject who had described her own eating habits as normal by enquiring about what she had eaten that day. It emerged that she had had a small lunch and no evening meal because she had

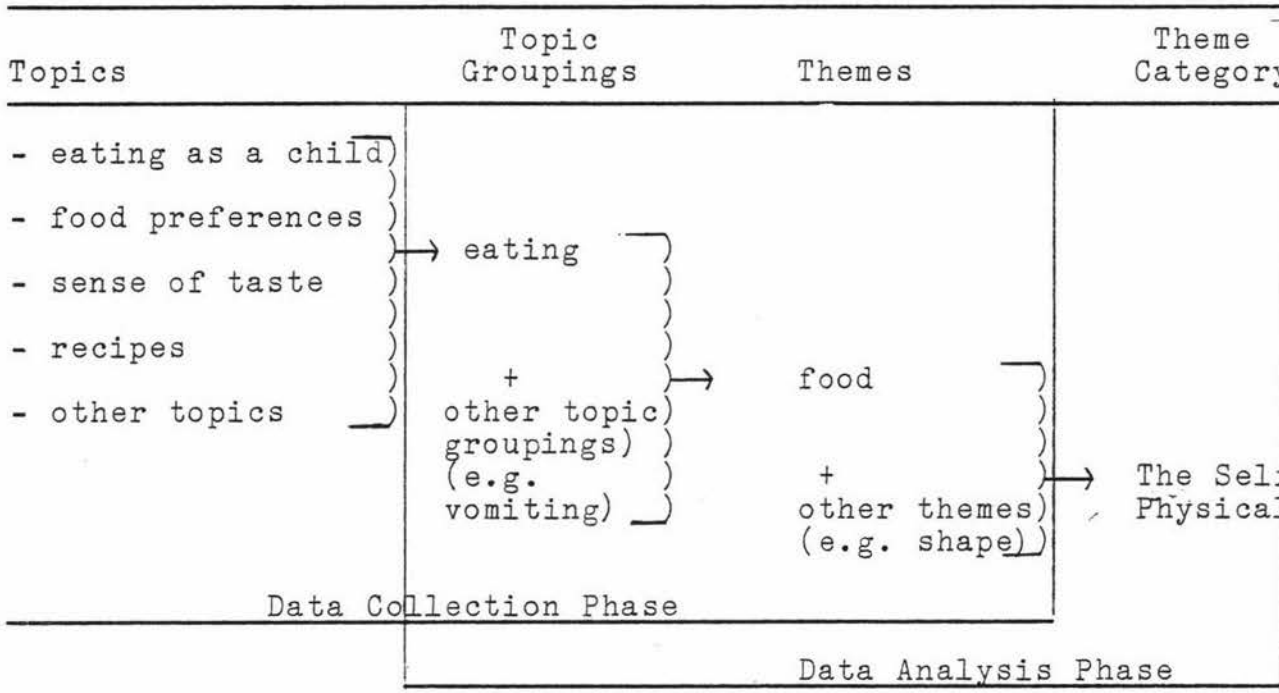
been to a fitness club, and this information then became the basis for further exploration. It was possible to check family reports of their interaction by observing this in action, and, in addition, material provided by therapists in some cases enabled a further check on these perceptions.

With regard to the overall analysis of the date on completion of the data collection, all the tapes and various notes were reviewed again. The tapes of the first anorexic-interview reviewed were analysed for their themes by initially determining a topic heading for every substantive statement made. These topics were then grouped to provide more comprehensive topic labels (topic groupings) and the material was considered again to check for any gaps. The same process was followed with the tapes of those other individuals associated with this first subject. Most of the material could be grouped into the same broad topics. Analysis of further tapes then used these same topic groupings and added new topics if this seemed necessary. Very few new topics emerged after analysis of all the data relating to the first anorexic. In each case the analysis of the data commenced with the anorexic's material first so that the anorexic's perceptions remained central. Also, all the material for one subject was analysed before moving on to the next subject.

The topics and topic groupings began to merge into distinct themes fairly early in the analysis period but the final determination of themes was left until all the data was collected and the overall analysis was well underway. The cross checking of themes back to topic groupings, topics themselves, and the original data was also part of the ongoing analysis both within data collection and overall analysis periods. Finally, theme groupings were made on the basis of the most reasonable and economical collections of the themes themselves, and these constitute the categories for writing up the data analysis. Four such theme categories have been determined. These are: The Self-Psychological; The Self-Physical; The Self and Others; and Intervention in the Anorexia. In Figure One the processes of topic determination, topic groupings, theme determination, and theme categories are schematically represented with regard to one group of

topics converging onto one theme category. The overlapping nature of the data collection and overall analysis periods for the enactment of this process is also portrayed.

FIGURE ONE: DATA ANALYSIS PROCESSES



CHAPTER FOUR

R E S U L T S A N D D I S C U S S I O N

This Chapter presents the results which emerged from an analysis of the data collected in the study and considers their relationship to existing findings evident in the literature. Initially a brief narrative description is provided of each of the subjects to provide a context in which to view the date. The results are then presented under the four major theme categories which emerged in the study: the Self-Physical; the Self-Psychological; the Self and Others; and Intervention. Each of these theme categories is made up of various related themes and examples of actual statements of the subjects from the data are used to illustrate and support the findings. A discussion of these and their relation to what has been already suggested about anorexia nervosa in the literature occurs at the end of each theme cateory.

The Subjects

Barbara was 27 years old, divorced and working in journalism at the time of being interviewed. She was the second child in a large working class family of six children. At 18 years of age she had been raped while on holiday and dated the beginnings of the disorder from around this period. After her marriage she had travelled overseas and had become more severely anorexic. She was hospitalized and given a range of treatments, the major one of which was individual psychodynamically-oriented therapy. At the end of her treatment she had separated from her husband. She was attractive, vivacious and talked easily about her experiences. In addition to Barbara herself, her parents were interviewed and Barbara supplied a diary and a letter home to her parents from the anorexic period.

Deborah was 16 years old, the third child of seven in a large farming family. She had just completed University Entrance and was returning to school to study for Bursary. Deborah was slightly deaf as her mother had contracted rubella while pregnant. Nonetheless she was involved in ballet and played several musical instruments. Deborah

had become anorexic at the end of her Form Two year and was still in treatment with a family therapist at the time of being interviewed. She had not been hospitalized. In appearance she was somewhat severe and very thin. She spoke quickly and softly, unlike many deaf people, and was hesitant in her speech. She was quite difficult to communicate with. Her sister, mother and father were interviewed, also her therapist was contacted, and a teacher from her school was seen.

Elizabeth was 35 years old when interviewed. Married with no children, she was employed in the social work field. The third of three children, her family were living overseas. She appeared to have become anorexic at age 22, although she had lost quite a lot of weight before that time. She had never been diagnosed or treated but fulfilled the specified diagnostic criteria. She thought she had probably remained anorexic for about four years, although she had not perceived herself as anorexic until very recently. She was easy to talk to and had an awareness of her own psychological functioning. In appearance she was small and fragile. In addition to being interviewed she also provided an extensive autobiography, written about a year previously as part of her professional training.

Karen was 18 years old and studying to be a teacher. Her parents ran a retail business. When interviewed Karen wore a baggy tracksuit and appeared extremely thin. She had been losing weight since arrival at the hostel where she lived, she thought, but had only seen a doctor about her amenorrhea. She fulfilled the specified diagnostic criteria. To talk to she was very quiet but appeared eager to please. There was a lack of affect evident, however, in her manner. When seen with her mother she became considerably more passive than when on her own. Information about Karen was also provided by a friend.

Sarah was aged 18. The eldest child of three, her father was in business and her mother was a teacher. She was working in the food industry prior to returning to university the following year. After leaving school she had gone to university away from her home area but had left after a few

weeks. She had developed anorexia nervosa during her sixth form year and had been hospitalized during her time in the seventh form. She had received a range of treatments, the central one of which was family therapy. When interviewed for this study she usually wore sports clothes, tracksuit or shorts, and when first visited appeared to be of normal weight. During the period in which the researcher met with her, however, she put on weight. She was initially very co-operative. Later however she stated that she did not wish to talk about herself further, although she agreed to allow the researcher to interview other people connected with her. Her mother, father and sister were also interviewed. Her therapist was seen, as was a teacher at the school she had attended, and a family friend also provided an additional perspective.

Tania was a 20 year old university student, intending to go into the field of social work. After leaving school she had started to train as a nurse but had become anorexic. She had been hospitalized and treated in a general medical ward and had not received any psychotherapy.

Teresa was 24 years old and was a nurse. She had become anorexic at age 14 and had been hospitalized and given a range of treatments, the central one of which was behaviour modification. In appearance she was, if anything, slightly overweight but had a waif-like expression. She seemed quiet, sensitive and thoughtful about her experiences.

Theme Category One - The Self Physical

This category is made up of four themes - food, including issues of eating, vomiting and bulimia; shape, which includes weight and size; menstruation; and exercise and activity.

Theme One - Food

The consideration of this theme addresses the subjects' experiences with food and feeding before they became anorexic, their attitudes and preferences during the anorexia and their approach now.

From the various interviews it would seem that for the anorexic subjects eating habits before the disorder do not appear to have been unusual. Barbara's mother did not remember her as being any different to her other children

with regard to food. "Her plate was always clean, just like everybody else's. That's why it [the anorexia] was such a puzzle". Sarah's mother recalled that Sarah had been difficult to wean and a battle had obviously developed:

> As soon as I put her on to solids she objected and she only wanted milk. But I, of course, felt she had to have solids.... I got totally distraught and so did Sarah. We'd both end up crying.

Deborah's mother, however, stated:

> She was a very contented baby. Ate her vegetables and that sort of thing. When she got to two she turned off in a big way and wasn't an easy feeder. The one thing she did love was lollies. We used to call her the 'lollyholic'.

The feeding experiences and the manner of their presentation and discussion in the interviews do not suggest anything notably different to what might be considered the early childhood eating patterns of the majority of people. Only the battle which developed between Sarah and her mother and Deborah's early passion for lollies perhaps hint at anything atypical with regard to food. Overall, food does not seem to stand out as having been an early problem.

During the anorexia, however, food clearly became an obsession. Elizabeth, Barbara and Sarah all counted calories obsessively. Barbara and Elizabeth kept diaries in which they entered everything they ate. Recipe reading and supermarket browsing also seemed to become very important, as a way of thinking about food without being faced with actually having to eat it:

> I really didn't like looking at food much except recipes. I really liked looking at recipes. If I saw the food in the fridge, I'd just about run a mile. (Sarah)

> I became very much into cookery. I used to read recipe books. I suddenly took this turn towards being a wife and, um..., you know, sort of revolved very much around food and food had a sort of fascination. (Barbara)

Deborah's mother reported a similar fascination with food in her daughter:

> She was terribly interested in helping me with food. I hadn't had to make a pudding for about a month because Deborah always wanted to make the pudding. So she was now feeding everybody else. (Deborah's mother).

The last part of this statement seems important. The food cooked was for others to eat and tended to involve high calorie recipes. Other people's eating often became carefully watched by the subjects, and for Sarah and Deborah this involved their sisters especially.

> I did do a lot of cooking. That way I knew that I was filling the tins up and that was going to tempt Lorna [her sister] in some way - or other members of the family. (Sarah)

> The first thing I noticed was when she used to start watching me and how I ate and Kirste [sister] too mainly. She used to pick at what we were eating and tell us we were getting skinny and weren't eating enough. (Deborah's sister).

With regard to their own eating the impression conveyed was that the subjects regarded food as a dangerous trap, always lying in wait for them. Food was planned ahead carefully. Barbara saw herself, for example, as having put considerable energy into avoiding eating situations. Elizabeth also planned ahead:

> I would bake a batch of bran muffins, put two in each packet and put them carefully in the freezer. I'd just eat two bran muffins and a little butter on about five or six days of the week.

They also seemed to have developed preferences for certain foods. In addition to Elizabeth with her bran muffins, Sarah ate marmite and yoghurt Deborah consumed large quantities of 'Complan' carefully measured out, Karen was eating mainly salads. It can be noted that these are all foods normally regarded as 'healthy'.

The overall picture during the anorexic period is that food became an obsession. Considerable energy was devoted to organizing it, and high calorie foods were prepared for others to eat but anorexics themselves preferred 'health' foods.

It was clear from subjects' statements, their families and observations that food was still somewhat problematic. Sarah's sister stated that she continued to be watched

by Sarah to make certain that she ate enough and that Sarah still spent much time discussing food with her mother. Tania said, "I'm not over it yet, you know. I'm still much too bothered about what I eat". Teresa thought that, if anything now, she was overkeen on her food. Elizabeth had married a man who cooked for a living, "I felt extremely attracted to the fact that he was a man who cooked but also because the food he cooked was so gorgeous, so tempting" (Elizabeth). The two of them had very different eating patterns and for Elizabeth a struggle existed between the temptation of her husband's cooking and her feelings of guilt if she ate a lot of it. Moreover the pantry contained very limited quantities of anything with a high calorific value, although there were many 'health food' preparations. Barbara said, "I'm a very healthy eater. I eat wholemeal bread and bran and beansprouts and things like that". It was discovered however that on the eventing she was interviewed she had not eaten an evening meal because she had had no time between work, her fitness clinic and the interview.

For the previously anorexic subjects in this study it was clear that a strong interest in food remained after the anorexia had abated. This could not be said to hinder their lives greatly, and in its concentration on healthy eating might be regarded as beneficial. Food remains a central feature in their lives however.

The subjects were also asked about bulimia and vomiting. There did not seem to be a pattern to the occurrence of these. Sarah had made herself vomit when she was developing the disorder. Tania had not thought about vomiting until she went into hospital, where she learned from other anorexics. Deborah's mother considered that Deborah had not thought of vomiting because she was too young when she developed the anorexia, although Sarah remembered trying to vomit when aged nine in order to avoid going to school. Neither Barbara nor Elizabeth had vomited, although both seemed somewhat regretful, "I'd never been successful at making myself sick, although I'd tried" (Barbara); "Vomiting is about the worst thing to Hell I can imagine.... I haven't got the willpower. Probably when I need to" (Elizabeth).

Bingeing behaviour or bulimia seemed to have occurred regularly. Elizabeth and Barbara had indulged in that might be described as controlled bingeing in the early stages of the disorder:

> When I came home for the weekends I used to find this terrible situation where I would scavenge everything in sight and I would find myself into the cake tins and eating everything and then feeling like a barrel and going back and starving myself. (Barbara).

Elizabeth's weekly plan involved calories being saved during the week and spent at weekends. Barbara too ate large quantities when she ate out.

> When I was out I'd eat two desserts and people would say 'My god, how can you eat that and be so thin?' But it was during the week I'd control it. I really lived on a weight-watchers' diet.

Sarah had experienced binges since leaving the hospital. She reported that she often had uncontrollable binges where she would think of something she hadn't had for a long time and then she would "get stuck into eating it".

The type of food eaten on binges was often the opposite of the usual diet for the subjects. Elizabeth ate rich restaurant meals, Barbara had two desserts and Sarah usually had "cakes, candied fruits, dates and mixed peel and cherries and those sort of things in packets, and packets of chips and sweet things. Quite a lot of cheese and so on". Her mother confirmed the bingeing pattern and mentioned her eating chocolate and sweets in particular.

Theme Two - Shape

This theme gives consideration to issues of weight and size during the periods concerned. There was no uniform pattern of weight level before the anorexia among the subjects, although none of the seven had been obese. The size of other family members was also not consistent. Barbara's mother was considerably overweight. Sarah and Elizabeth described their families as thin, and both of these said that they themselves had been somewhat tubby as children. "Other people tell me I was just tubby [as a child] but I felt I was enormous" (Elizabeth).

Barbara and Deborah both began dieting because they felt they were too fat. Barbara weighed 8½ stone (54kg) at that point but thought she had a 'pot' stomach, and Deborah, who was involved in ballet, was concerned about her thighs. "I think I thought I was starting to get fat. I think I thought my thighs were getting big or something" (Deborah). Elizabeth too had been concerned about her thighs, and also her waist and ribcage:

> When I looked in the mirror and I saw my thighs, they always looked to me to have a big blob where they hitched onto my legs.... It's always been my ribcage that's been the most difficult bit. I think I'm quite 'blocky'. My ribcage sits on my waist.

Looking at the concerns of the subjects overall about their shape the area concentrated on was mainly the trunk and the thighs. Some attention was given to other parts of the body but most concern centred on these locations.

Where other people were mentioned with regard to negative comments about size, these tended mostly to be male relatives. Elizabeth felt her father disapproved of her chubbiness and that her brother was disgusted by her. Sarah had an uncle who made fun of her:

> He'd pay us, well he'd pay Lorna and Charles, five cents for doing this little job. And yet I'd only get two cents and he'd be calling me fatty and so on, and it really got to me. (Sarah)

For Barbara and Elizabeth their husbands' opinions of their size were important, "Once in a restaurant Andrew said 'Oh, you pig!' My image of myself suddenly expanded" (Elizabeth).

The lowest weights each had achieved during their anorexia varied. Sarah had reached 6 stones 8 lbs (42kg). Deborah said her lowest weight was about 5 stone (32kg). Elizabeth weighed 6 stone 3 lbs (40kg) at her lightest. Barbara 6 stone 7 lbs (41.5kg). Karen said she was 6 stone 7 lbs (41.5kg) the time of the interview although from her appearance she might have been even less than this. Both Barbara and Elizabeth reported feeling very good at their lowest weights. Elizabeth said "When I lost weight I moved very quickly and I seemed to have lots of get up and go. I felt sort of electric", and similarly, Barbara stated, "I felt incredibly

healthy, incredibly energetic". For Deborah whose weight went lower, however, lack of energy became a problem, "At the time when I was underweight, I felt weak. At dancing anyway - I do ballet.... When major exams came along I did try and put on weight and I usually did" (Deborah).

What was it for the subjects that provided the initial impetus to lose weight? Elizabeth had her tonsils removed, lost weight and claimed she was so impressed that she continued to diet. Barbara thought she was fat after a holiday abroad. For Karen and Tania dislike of hostel food was an important factor. Sarah wanted to be a better sprinter and Deborah, who had just entered puberty, appeared not to have wanted to develop physically.

The rewards for actually being thin included a pleasure in clothes, the sight of bones which had not shown through before and the attention of others.

> I was down to a size seven at one stage and clothes became of great importance to me.... The more bones that started to show, the better I thought I looked. Those were the days of miniskirts and to some extent I <u>was</u> gorgeous!.... I'd think,'If I'm thin now, I'd better get thinner because then I'll get the remarks even more'. (Elizabeth)

On the other hand Deborah was annoyed by attention, since it made it more likely that she would be stopped from losing weight and Karen and Barbara wore baggy clothes so that size was less noticeable. Tania in the interview asked anxiously, "Does it show?" (that she had been anorexic). Scales became an obsession for the subjects, "I can remember going into town practically every morning and going to the Woolworths and hopping on the scales before I went to work" (Elizabeth).

The thought of gaining weight was an ongoing dilemma. Barbara's diary provides a picture of how difficult it was to face gaining weight:

> Thursday 28th:... Was bluffed this morning in ward about target weight which was set at 8 stone 6. (53.6kg). I was so relieved that it wasn't 8½ that I didn't realize till I left that it was only one pound less.

> Friday: felt panic-stricken to have put on four pounds in four days....
>
> Saturday 8th: my anxieties about my target were met with an unsympathetic ear
>
> Wednesday 26th: 8 stone 6 is just too high and I feel O.K. at this weight [7 stone 13 lbs, 50.5kg] although it's all around the bum and tum.

In addition she complained frequently of stomach pains during the period of weight gain.

At the time of the study two of the subjects were still noticeably underweight. Deborah weighed 7½ stone (47.7kg) and was still in treatment, and Karen weighed 6½ stone (41kg) at the most. Tania looked rather thin for her height but her present weight was not stated. Barbara weighed 8 stone 3 lbs (52.3kg) and Elizabeth 7 stone 9 lbs (48.6kg) with these perhaps being on the light side of average for their height and build. Both Sarah and Teresa appeared slightly over-weight, with Sarah putting on weight during the course of the research.

Theme Three - Menstruation

None of the anorexics had menstruated while they were anorexic and two of them, Karen and Deborah, were not menstruating at the time of the study. Deborah (aged 16) had never achieved menarche, and Karen had ceased menstruating about six months before.

Both Sarah and Elizabeth developed amenorrhea at about 7 stone (45.5kg) and Karen and Barbara at about 7½ stone (47.5kg). Barbara had found however that for a time her periods had been irregular and appeared to be stimulated by meeting men she found attractive:

> My periods disappeared about that time [7½ stone/47kg] And the odd thing was they'd disappear maybe for about six months and then I'd meet a guy and go out and the second time I'd see him or something suddenly a period would come back out of the blue.

None of the anorexics seemed bothered about the amenorrhea and some expressed relief. Barbara had associated menstruation with "puberty and pads and all the horrid things about being a woman" that she did not enjoy and Elizabeth found the amenorrhea rewarding:

> I hated my periods. I think I was aware that it was to do with my reproductive ability. I think that it was one of the reasons.... that I deliberately maintained my weight at 96 lbs (43.5kg) for, oh, about four years.

Sarah's therapist also mentioned Sarah's dislike of her periods and that this appeared to be linked to premenstrual tension which was commented on by her mother and Sarah herself. Since menstruation had resumed however, this had been much less a problem.

Menstruation appeared to resume at a slightly higher weight than it had ceased for the subjects. For Elizabeth this was at about 7 stone 6 lbs (47kg), as against 7 stone when it ceased, and for Barbara about 8 stone (51kg) against 7½ stone. At 7½ stone (47.7kg) Deborah had not yet menstruated. Both family and therapist recognized this as an important next step in her recovery. Her mother considered that she had been approaching menarche at 12 years when she became anorexic.

Menstruation would appear to be linked to weight level and to resume at a slightly higher weight than when it ceased. However it appeared to have quite a high degree of emotional significance for the subjects. Also Barbara's menstruation was apparently affected by her emotions on meeting an attractive male. Emotional stress alone however, had not been sufficient in Sarah's case to affect her menstrual cycle. After the anorexic period she had left home to go to university and had been very unhappy but this in itself had not affected her cycle at all.

Theme Four - Exercise and Activity

Considerable interest and involvement in exercise both during and since the anorexic period was evident with the subjects. This seemed mostly aimed at maintaining fitness and using up calories. Some families but not all had been interested in sport. Sarah's whole family had been interested in the past and still were very keen. Her father had been involved in athletics and water sports and her sister was considering Physical Education teaching as a profession. The family had belonged to an Athletics Club.

Various pieces of sports equipment were evident about their house. Before her anorexia Deborah had been a good runner and her father had been disappointed at the way the anorexia put an end to this. Deborah had continued with her ballet, however, with support from her mother. Barbara stated that she had not been interested in sport as a school girl, although her father remembered her playing hockey for her high school.

During the anorexic period any exercise was perceived as using unwanted calories. Several subjects walked rather than use public transport or lifts.

> We lived about six miles from town and I made a point of walking back and forth into town each day and I worked in an office building of 21 storeys and I walked those 21. (Elizabeth)

Barbara also did a lot of walking and "rushed around" doing things frenetically like housework and being very tidy, these things giving her a food feeling. Elizabeth commented on how active her mind felt, "My mind seemed to be a hell of a lot more active too. Everything seemed to be so acute, a really sharp outline". After reaching target weight in hospital Barbara appeared to cope with her increased weight by trying to get as much exercise as possible. Her diary stated for instance:

> Wednesday 9th: Walked around rugby pitch in afternoon and felt stuffed again which reinforces to me how unfit I am. Arches of feet sore and thighs aching.
>
> Friday 11th: Five circuits of the large ground.
>
> Sunday 13th: Felt a lot better after 5 circuits of the pitch. Bit worried about that as I am making a daily habit of it and feel the need to more and more - is it excessive? (Barbara)

Subjects seemed to be still actively involved in exercise and fitness. Barbara attended a fitness clinic twice a week and was working to increase the distance she was running each evening. Elizabeth jogged for about three miles each morning. Deborah was still pursuing her ballet. Sarah however appeared to want to exercise but not to know how this might be done without it becoming an obsession:

> I've not joined any sports clubs or anything. I'd like to. I couldn't imagine myself sprinting again. I had a pretty strong willpower when I'd gone into hospital, it was one thing that sort of deadened in some ways. I could have that willpower if I wanted to have it, but I'm scared to have it. If I did I'd probably start running immediately. (Sarah)

It is interesting to note that the exercise chosen by the subjects invariably involves non-competitive individualized activity. These activities might be said to involve more of a battle with the self than one against others. As with the ongoing emphasis on food, this seems not to be regarded as a hindrance to the subjects and has some positive value in that it probably contributes to general health.

Summary and Discussion: The Self-Physical

A number of notable features emerge from the data in this theme category and some comparison is possible with the positions and findings that have emerged from the review of literature. There was no support evident for the psychodynamic view that early eating patterns, especially during infancy were linked to the disorder. Moreover, the strange eating preferences, often identified in the diagnosis of anorexia nervosa seemed with this group more to do with choosing non-fattening 'healthy' food and associated with the determination to be thin. The obsession with food appeared to be prompted by an ongoing internal battle between the determination to lose weight and a real attraction to food rather than to any personality type. The act of feeding others seemed to be part of a compromise with this, but also seemed to indicate something of an aggressive impulse towards others. This picture of obsession and aggressive impulses conforms with that evident in the work of Bruch (1973, 1978) and Selvini Palazzoli (1978) in the ego psychological stance. Some vomiting was experienced but not for all subjects and it did not seem to relate to the individual severity of the disorder. Bingeing was common and there was some evidence to suggest that treatment experiences might encourage bulimia as postulated by Bruch (1974). Bingeing appeared to result from a brief loss of the strict control over eating, which was then reinstated and the foods eaten in binges were the ones normally avoided. The most significant finding with

regard to food itself was the extent to which all of the subjects still felt that food was problematic for them. Yet this consistency is not evident from the literature and more general outcome studies seemed to focus on serious problems to do with food and not recognize its level of individual concern.

No pattern regarding weight of the subjects or their families before the anorexia emerged, except that none of the subjects had been seriously over- or under-weight. Dissatisfaction with appearance was centred on the lower part of the trunk and thighs which might suggest connections with sexuality, as in the psychosexual stance, especially as the criticisms which the subjects had taken most note of about their appearance were made by men. The severe distortion of body image discussed by some writers in the literature did not seem to conform to the experiences of the subjects in this study, since on the whole they seemed quite aware of how thin they actually were. Weight loss involved several rewards that were important including attention and admiration from others. This would seem to conform with the behavioural perspective regarding the influence of rewards and reinforcements for achieving and maintaining weight loss (e.g. Williams, 1976). Gaining weight caused some clear stress and also physical discomfort.

Menstruation appeared to be linked to weight as suggested by Bruch (1973), but also had some psychological meaning for subjects, which appears to perhaps support Crisp's (1980) view that anorexia nervosa represents a refusal to adopt an adult female role. It seemed to free them from some of the constraints of womanhood. It could also be suggested that it was representative of some sense of control over their bodies. The level of activity found in the anorexic period for these subjects seemed to be related to the desire to lose weight and maintain fitness. Subjects also recorded feeling very alert. Hyperactivity as a diagnostic factor for this group might seem to be related to a 'pursuit of thinness'. Again it was clear that the subjects were still very interested in exercise, having incorporated it into their normal living. This too, in its existence and preferences for particular

activities, may be seen as a desire to control the body and master its functioning.

The picture of the physical self which emerged from the subjects was very much in keeping with that which emerged from the literature. What emerged that was not part of the established picture, however, was the fact that food as a problem continues to be represented in everyday life patterns; also that 'anorexic' behaviours in moderation could actually be seen as quite healthy. This suggests that the transition into and out of anorexia nervosa is not at all distinct and that the resolution of the disorder itself may be tenuous. The question of control of the body and its functions seemed to be an important implicit and at times explicit issue. This was evident with regard to food (including vomiting and bulimia), menstruation and exercise.

Theme Category Two - The Self Psycholocial

This category consists of four themes which emerged related to psychological functioning. These are willpower and control; self-concept; sexuality; and approach to work.

Theme One - Willpower and Control

Early in the analysis of the data it became clear that the theme of willpower and self-control featured prominently in the anorexics' experiences. It was evident in relation to study and schoolwork, dieting, the denial of anorexia and the treatment they received.

The pursuit of thinness, recognized as a central feature of the syndrome, was perceived by the subjects as a battle not only between themselves and others but also between the individual's willpower and the temptation to lose control. The battle with others was typified by Tania when she stated:

> That's one thing (the success of being anorexic) that made it quite hard letting other people help me when I was anorexic, because I was successful in my own way being that. I was beating them all in some ways. I was getting my own way."

The sense of internal control seemed even more exhilerating,howeve

Elizabeth stated that she loved feeling hungry. It felt good for her to know that her stomach was demanding food and she

wasn't giving in to it. Teresa suggested that it takes a certain sort of person to become anorexic, "I think it takes an ambitious self-disciplined person".

The self control extended to other areas of the anorexics' lives as well, and provided a way of approaching many difficult situations:

> I was extremely set in my habits. I've gotton very lax over the last few years but when I first met Andrew, the ritual of the bran muffins was repeated in just about every area of my life. I set myself, if I wanted to do something, I set out the steps and just followed this religiously. (Elizabeth)

Sarah described her determination to sprint after achieving very poorly at this activity, "I got really determined and I started training". The determination and application were obvious in the approach taken by subjects to schoolwork and study. The subjects had been successful in their studies largely because they had worked so hard. At the time of interview Deborah had just been accredited with University Entrance, second in all her sixth form and Karen was described by her friend as an extremely conscientious person. Sarah's teacher said she was "competent, a satisfactory student as opposed to a brilliant student .... Her practical Physics book was immaculate, quite one of the best I've seen for many years". For Sarah herself success with her studies was very important, "Surely I could have success somewhere, so I really worked hard at my schoolwork". Elizabeth in her autobiography identified the link between her desire to succeed and her fear of a loss of control:

> The more I review my history the more clearly I see the pattern recurring: avoiding anything which I doubt I can do to my own standard - ideally, error-free - and, once committed to something, making a crusade of seeing it through to the finish. At base is that rank fear that if I get distracted from my goal, I'll lose control. (Elizabeth)

Both she and Barbara had returned to study at a time when this involved personal sacrifice and considerable self-discipline.

Success brought admiration, and was thus a way of gaining attention. Tania stated that she sought attention

from her parents and others through her success and Barbara remembered her father's praise being always important to her because she was competing against six others. In his interview Barbara's father did indeed praise her for her organization and success.

The denial of the disorder, rather than being an area in which the anorexic appeared unaware herself, seemed also to be a part of the determination issue. By denying the problem there seemed to be something of an attempt to avoid intervention. The only area in which the subjects did appear to have clearly denied the truth to themselves was the risk of death. Sarah in discussing her mother's attempts to persuade her that she was ill said:

> I suppose I was really cutting her off and listening to what I wanted to and cutting out what I didn't want to hear .... I knew what was really happening but I didn't want to really look at it. (Sarah)

Deborah in talking about the danger said that when she first heard about anorexia, she didn't regard it as having the risk of being fatal for her, "You think, 'Oh, that couldn't happen to me!" Deborah, Barbara and Elizabeth all realized how thin they were. Sarah, even though she hoped, "It was going to be for a life-time", also wanted someone to intervene and help. Karen although she began by saying that nothing was the matter and that people were fussing unnecessarily finished the interview by asking for help. Although senses for Sarah were dulled, and somewhat denied, Elizabeth and Barbara were both aware of their hunger. Sarah said:

> I think when I was getting sick my sense of smell and taste seemed to get worse. And that was O.K. by me because I didn't want to taste things or smell them. (Sarah)

But Barbara suggested that the sensation of hunger became perpetual and therefore was not so easily recognized, "I didn't need to eat much to feel full. You pop something down there to shut it up but no way do you satisfy it." (Barbara).

Although reducing food-intake was perceived as a way of maintaining control, the anorexics became trapped as their not-eating also moved beyond levels of control.

Treatment therefore inevitably involved a relinquishing of control of eating in order to obtain control of life in more general terms.

> I was admitted to the hospital and at that stage I succumbed to what other people told me. I ignored, or tried to ignore my own feelings. (Barbara)

Sarah found it helpful to recognize that getting a quick recovery was in fact helping herself so much. Barbara's parents commented on the extent to which she appeared to have lost control of her life while she was anorexic. Her mother found it hard to understand why normally such an independent person had not driven a car for 18 months and concluded that previously Barbara had tended to appear more capable than she actually was.

There is a certain flavour of religious asceticism throughout the subjects' material relating to control. Only one subject, however, referred to it directly. Her anorexic period had co-incided with a temporary involvement in a strict religious sect.

> It (the weight loss) must have co-incided with the religious thing. Whether that meant I was wanting to be a nun or not, not wanting to have any of the pleasures of the world or to be very self-denying, I'm not quite sure. (Elizabeth)

She also wrote in her autobiography:

> There was positive virtue in self-sacrifice; which pore of my being did that come through? If I was tempted to be extravagant, fashionable, wasteful, lazy, pretty, glutonous, frivolous .... I would conquer them all. (Elizabeth)

It is in relationships with others, however, that control issues seemed most central to the subjects at the time of the study. Elizabeth had determined never to have children, and Sarah's therapist stated that it had been raised as an issue in her treatment. Barbara indicated that she knew herself well enough to know that if she was going to be a mother, she would have to be a very good mother, and that she knew that she would unwittingly give up more of herself than she meant to for her children. Elizabeth had worked hard not to lose her feeling of self-control in her marriage. She had known from the time she was old enough to identify with her parents'

marriage that she didn't want the same for herself, "I would be under someone else's instructions". It was obvious from her married life that Elizabeth had set strict boundaries to the relationship which included separate bedrooms, separate friends and leisure activities, separate holidays and an agreement not to have children. In addition she and her husband frequently ate separately. Barbara had ended her marriage after she recovered from her anorexia, since the relationship did not allow her the space to be her non-anorexic self. In a letter to her parents at the time, she stated that her husband had taken over control for her, "I really felt looked after and that is what it is all about". The desire not to be controlled remained strong in Deborah too.

> I feel its not the best way to try and force [feeding] like that, because you immediately start rebelling. You feel sort of 'Why should I?' sort of thing. You don't like to be spoon-fed. (Deborah).

Struggle for control was a major issue between Sarah and her parents. Her father said that she still had an adamant approach typified by, "I have a right to whatever I wish, how I wish and when I wish' without any reference to the rest of us".

It would appear that issues concerning control played a large part in the anorexia and were still evident in the lives of the subjects after recovery as well. Several subjects expressed regret at the apparent reduction in their willpower which had resulted from an improvement in their anorexic state.

Theme Two - Self Concept

A picture of the self emerged from the subjects overall which suggested that a somewhat negative self concept was combined with an air of depression and at times suicidal feelings. Negative feelings about the self were linked mostly to negative feelings about appearances. The ideal self was seen as thin, energetic, successful and attractive.

> I remember being influenced by a family friend when I was about sixteen, a lady who was very bright and efficient and attractive and such a contrast physically to my mother. I noticed she used to watch her weight, she used to not take another biscuit. (Barbara)

The opposite of this, the self that subjects didn't want to be,was

described by Elizabeth:

> I'd always seen myself as being very sloppy and very ponderous and very slow .... If I could shake my real addiction - to fear as my slave-driver - I might revert to the creature that lurks just out of sight. Fat, unlovable, incompetent. (Elizabeth)

Sarah's sister, when asked why she thought Sarah had become anorexic answered that she thought that it was mostly because she wanted to be like everyone else and not to be herself.

The split between the ideal and the feared self appeared to lead to a sense of 'phoneyness' which subjects experienced in themselves and feared in others. Elizabeth was popular as a child and as an adolescent but felt that no-one in her family, including herself, could understand why. At her baptism into the religious group which she had joined, she described her realization that she had made a mistake:

> Did I imagine it or did it become crystal clear to me in that brief moment, being held under water, that I was a phoney and a liar? (Elizabeth)

She immediately left the group, an act which she found very difficult. Sarah felt insecure because she did not know if other people's reactions to her could be trusted:

> It [two-faced behaviour] really annoyed me. It was one thing that made the world look so ugly. It was as if people weren't honest and I couldn't tell if they were liking me as a friend, as their daughter or what. I think it was more of a personal hurt that I couldn't tell. (Sarah)

These feelings led to depression and in some cases suicidal feelings. Sarah described how she started shutting herself off. The world started to look really ugly to her andit was at that stage that nothing could really stand in her way at all. If anything did, she was quite happy to consider doing something quite drastic to herself. Her response was to see herself as just another burden to everyone and that everything would be quite alright if she was right out of everything. A letter from Barbara to her parents stated that before she went into hospital she was feeling depressed and as though she was losing herself, her identity and confidence and that she could no longer achieve any of the things she wanted to do.

The experience of the anorexia appeared to have added to the poor opinion of the self. Karen apologized for being a nuisance to people, Tania was ashamed of having been anorexic, Teresa brushed her experiences away by stressing how long ago it all was. Barbara said, "I hate telling you these things about me because I cease to become me. It was a survival thing". Deborah described how she would be when she was better as having enough confidence, and being happy and less self-conscious. Other people would accept her more, she would look better and would find it easier to mix.

The emphasis on appearance is congruent with the negative image of the real self. It was as if only by unceasing efforts would the exterior self not betray the feared self within. Elizabeth despised her "mirror image" and sought boyfriends on the basis of how others would regard them. Barbara described herself as "Ten-Ton-Tess" when she reached target weight. Sarah's mother linked social acceptability with appearance:

> She was always quite muscular in her thighs and, umm, she tended to have not an easy relationship with other children. (Sarah's mother)

Theme Three - Sexuality

Sexuality emerged as a theme which had links with both control and self-concept issues. It seemed to be an area where anorexics were especially afraid of losing control of their own lives and in addition they lacked confidence in their sexuality. An apparent dislike of menstruation, discussed earlier seemed also to be linked to feelings about sexuality, and similarly concerns about shape were suggestive of difficulties within this domain.

Both Barbara and Elizabeth had felt that enjoying their sexuality was not for them. "I just decided sex wasn't for me. It was always in the dark and under the covers .... After all, there was a lot more to life than that!"(Barbara). Elizabeth remembered that she had no interest in sexual intercourse when she was underweight. Although Sarah stated that sexuality had not been an issue for her despite the therapist's attempts to discover this, other evidence suggested that this might not be true. The therapist had noted not only

a dislike of menstruation but also displeasure at the idea of having children and an ignorance of sexual functioning. Moreover an incident recalled by Sarah's mother suggested that some conflict in the family might have arisen over Sarah's emerging sexual identity in early puberty. Also, her teacher commented that when he put his arm around her to congratulate her on her school performance "her response was such that she didn't know what to do" (Sarah's teacher). Sarah had had one boyfriend since she came out of hospital but had discontinued the relationship before her exams in order to work harder. Barbara noted that she had perceived her career as an alternative to emphasizing her sexuality, which she described as, "that womanly thing that I'd never had time for, that I'd virtually shut out of my life and got into the career and that". Deborah had begun to be anorexic at the time when she was moving into puberty. Her mother remembered buying her a bra and being surprised to find that Deborah was not pleased with this at all:

> What I really think triggered this non-eating was I went and bought her a bra .... I thought she'd be delighted. She wasn't, she said 'Oh, huh, huh! She pushed it - I found it, it was all screwed up still in its paper bag right at the back of everything. She didn't want to grow up, thank you! (Deborah's mother)

What did growing up mean to Deborah? When asked she said "responsibility" and when asked further what she meant her first response was "looking after kids".

None of the subjects wanted children. Elizabeth and Barbara had both made this clear to their husbands:

> I am sure now that for my ideas of motherhood and marriage I looked to my own mother, feeling she submerged herself, raising six children, stifled her ambitions, deprived herself, let herself go physically and became a wife and mother in every sense. (Barbara)

In this way sexuality may be seen as leading to marriage and children which brings about a loss of self-control. The relationship of self control to sexuality was explicitly highlighted by Elizabeth who said that she had had "a full-blown phobia about becoming the sort of person who is addicted to sex; who risks everything to satisfy a primal

need I simply hadn't yet felt".

None of the subjects saw themselves as sexually attractive. Elizabeth mentioned "the conviction that I was nondescript to all eyes but my own", and Teresa stated, "Although I always was feminine, it was very shallow. I could never reinforce it with a feeling of confidence in myself as a woman".

Barbara dated the beginning of her anorexia from the time when she was 18 years old and had been raped on holiday. Bad feelings about herself, for she felt guilty, and fears of pregnancy had led her first to overeat and then to diet. The latter part of her treatment in hospital involved considerable work on her sexual feelings and her marriage, as is evident from her diary. Although Barbara did not discuss it in these terms, rape is certainly frequently perceived as a loss of control of the self.

To an observer Elizabeth and Barbara would have appeared the most sexually confident of the subjects. Deborah had a somewhat "nun-like" appearance, so described by her mother, Karen was not an adult female shape. Only one of the seven, Elizabeth had a long-standing relationship. Barbara had had two sexual relationships since her marriage ended but neither had lasted. None of the other subjects had boyfriends.

Theme Four - Work

Since the work chosen by the subjects seemed to represent for them an important aspect of their psychological functioning, this theme is included in the theme category relating to the psychological self.

Some of the subjects indicated an interest either past or present in working with food. Sarah, having left university after the first few weeks, had obtained a temporary position in the food technology area of the food industry. Although she was not qualified for this, the firm had been impressed with her knowledge. She had also worked as a waitress at one point. She was intending to return to university the following year to study food technology. She said of her job:

> I work under a food technologist .... They [panels of tasters] taste these things that I put before them, whether they like them or not!

The situation seemed in some ways reminiscent of her determination to get her sister to eat. In addition she was doing tasting tests on food herself. Elizabeth had been involved in the catering industry with her husband for several years. She had also considered doing a degree in Home Science at the time she had decided to undertake university study.

Deborah, still at school, expressed an interest in nursing, dietetics and pharmacy as possible careers. When asked why she was interested in these, she said:

> Caring for other people. It's interesting, body functioning and things .... Mum was a nurse.... Dietetics, I thought that would be helpful, knowing how to look after people when they're sick, knowing how to feed them and that.... If I do become a wife and mother, you know, when there's sickness in the family, that's where nursing comes in too. (Deborah)

Nursing was the original career chosen by Tania although she had given this up after her anorexic period and Teresa was also a nurse.

Elizabeth, who had begun her adult life as a secretary was now involved in social service work. Karen was training to be a teacher and Tania a social worker. Only Barbara of the seven was not involved in or intending to undertake welfare work of some kind. She was a journalist. It is evident from her diary however that she perceived helping others as a strong source of good feelings for her. There are numerous references to experiences in hospital where she felt she had helped others to talk:

> Friday 29th Was involved in group this morning and felt I had achieved something by getting one or two of the shyer girls to talk.

All the subjects were involved in, or intending to take up work that required tertiary study. They had also mainly chosen traditional female careers where the work involved an extension of accepted female roles. The most notable feature was the preference for work which involves helping people.

This was further born out for example by reports of two other anorexics known to Deborah's mother. One, her sister, had become a teacher of the deaf and the other, the daughter of a friend, had taken up nursing.

Summary and Discussion - The Self-Psychological

Power and self-control are not issues directly focused upon in the literature on the disorder, although the inverse, a sense of ineffectiveness and a loss of control are noted for example by Bruch (1973) and Minuchin et al (1978). Yet for the subjects in this study at least, their struggle with their bodies seemed to focus on a major and wide-ranging determination to maintain an iron control of themselves and to succeed in the face of opposition from others. Control had, however, emerged in the literature in an indirect way, being a concern in the material on the therapeutic relationship in the psychodynamic and behavioural approaches and in family therapy work. The strength and consistency of this theme with the subjects suggests that it may perhaps play a significant part in the disorder itself as well as in its treatment; more, perhaps, than has been previously realized. The unaware denial of the problem which appeared to be a feature of the syndrome as suggested in the literature was not evident here. Subjects had been aware, at least most of the time, that a problem existed and what denial there was was somewhat manipulative and linked to a desire to be allowed to continue. The picture with regard to study conforms to that presented in the literature. The striking factor again being the sense of determination to do well at whatever was undertaken.

The self-concept in relation of anorexia nervosa was discussed in the literature and all three approaches attempt to improve this as an objective in treatment. The division between the real self and the ideal self that emerged here was noted also by several writers, and Selvini Palazzoli (1978) noted the manner in which this division was concretized within the emphasis on appearance. Depression and suicidal feelings have also been recognized in the literature, and seen most clearly usually after treatment for the anorexia. In this study subjects were also aware of being depressed

while anorexic, with this being illustrated in their disgust with themselves and with others.

Sexuality and work as themes seem also to a certain extent to converge on matters concerning control and self-concept issues. Subjects seemed reluctant to take on traditional adult female roles such as those of girlfriend, wife and mother. This appeared to a large extent a result of a lack of confidence in themselves as being sexually acceptable but also a desire not to be dominated by the needs of others. This would appear to be in line with the ego psychological notion of a fear of invasion by others. Work appeared to effect some compromise between the need to be feminine and the desire to achieve highly. In addition it provided a way of improving a poor self-concept by helping others. In some cases, and remarkably consistently, work provided an extension of the interest in food and bodily functioning. Findings from outcome studies in the literature which included vocational adjustment as a criterion made no mention of the types of work which subjects had been involved in, so it is not possible to provide any comparison.

When the issues of power and self-concept are considered together they provide something of a different perspective on anorexia nervosa. Literature on the psychology of women, such as by Baker Miller (1976) has noted women's tendency to internalize feelings such as anger and their tendency to judge themselves harshly. Writers on anorexia nervosa such as Boskind-Lodahl (1976) and Selvini Palazzoli (1978) have considered the disorder from a psychosocial perspective and have noted the conflict among the roles available to modern women. Lawrence (1979) has commented on the 'control paradox' whereby the anorexic's attempts to control her body lead to others taking control for her. It is possible that the need to be powerful is, like anger, turned in on the self as a result of the difficulty women have in seeing themselves as powerful in contexts outside of their families. The harsh self concept provides motivation for the anorexic to improve herself by strictly controlling the 'bad' aspects of herself. This would explain the subjects' regret at their loss of willpower with the passing of the anorexia.

This aspect of the disorder, if it exists as suggested, entails some important implications for treatment. The treatment perspectives which are possibly closest to this understanding are the ego psychological stance, which by encouraging separateness and development of the self is likely to enable the anorexic to explore her desire for power in other areas of her life and family therapy which enables the anorexic to exercise more appropriate power in her family. Treatment methods which remove control from anorexics and which fail to work at restoring and building a sense of power and self-control, although perhaps initially effective are, as suggested in the literature, unlikely to involve any long-term resolution of these issues. This criticism is not restricted to any one of the treatment approaches discussed in this study, as it seems to be very much an issue to do with the meanings and philosophy behind the concept of treatment itself.

Theme Category Three - The Self and Others

This category considers the data which was collected relating to the style of the subjects' interaction with others, aspects relating to the nuclear family, the extended family and relationships outside the family.

Theme One - Interaction

Material which emerged to form this theme arose from consideration of particular aspects of the subjects' communication with other people. This included withdrawal and isolation during the anorexia, passivity and deception of others.

Both Karen and Deborah, the individuals with the existing anorexia, were quite withdrawn at the time of interview. Much of Karen's interview was conducted at a very superficial level and it was hard to make contact with her as a 'real' person. Deborah spoke very softly and quickly, using short sentences which made it hard to follow what she was saying. Sarah talked about trying to shut everyone out during her anorexic period, "When I had anorexia I just tried to shut myself off from everyone". This was echoed by her parents. Deborah's parents also experienced her withdrawal and isolation, particularly from physical contact:

> We noticed afterwards, looking at family photo-. graphs, there'd be a group and she'd always be on the outside, always on the edge looking in. (Deborah's mother)

Barbara stated that she withdrew into herself after being raped and Elizabeth remembered that she and her sister, who was living with her at the time had very few friends at the time she was eating least. Karen had lost friendship and support from her peers, apparently because of her refusal to see 'sense' about her eating.

Withdrawal and isolation meant "bottling up" feelings (Teresa). Barbara commented that"anorexia makes you very, very tight and very emotionally together". The tension engendered by this seemed to lead to what Deborah's mother described as "irascibility" which was also referred to by her sister. The same pattern of interaction was described in Sarah's family.

Passivity was another feature of the anorexic period. It was evident in Karen's approach to her weight loss and her behaviour in the presence of her mother. Several times Deborah during interview suggested the researcher ask her mother for the answers to some of the questions, rather than her answering them herself. Sarah, in talking about making friends said, "I sit back and sum people up for ages and ages and often by then it's too late". As a child, as part of the battle over weaning, Sarah had apparently rejected food in a passive way by holding it in her mouth. Elizabeth however, had not been the passive one in her family but had resisted her father much more actively than her brother and sister had.

Deception played an important part in interaction during the anorexic period, but seemed to be confined to the struggle over food and losing weight. Karen and Barbara both wore baggy clothes to avoid their thinness being noticed. Sarah took yoghurt for lunch because it could easily be flushed down the toilet and Barbara hid biscuits up her sleeve and pretended to chew. When Deborah's family finally realized that something was wrong with her, they noticed how she engineered heated family discussion before slipping out of her

seat to put most of her dinner in the 'pig bucket'. For parents this deviousness seemed especially hurtful:

> The awful thing was that I had a sick child who was being so devious with me, who seemed to lie when she'd never been devious or a liar before. (Deborah's mother)

Theme Two - The Nuclear Family

Material in this area was wide-ranging and covered fathers, mothers, the relationship between parents, siblings and the family as a whole.

Fathers. On the whole fathers seemed to be distanced from the rest of the family, to be less involved in what was happening than other family members. In some cases the anorexics preferred this arrangement, in others there was a longing for a closer relationship with them. Both Elizabeth and Barbara expressed some dislike for their fathers. They saw their fathers as competing with the children for their wives' attention. As a result fathers seemed happier since the children had grown up and left home.

> He felt that he was competing with them [the children] for my mother. He's quite covetous now about having the house to himself and having Mum to himself. (Barbara)

Deborah and Sarah on the other hand appeared to want to be closer to their fathers. Sarah expressed pride in being like her father and admired his former sporting prowess. Deborah wished to marry a man just like her father, who was her ideal man. Her mother stated:

> I noticed that the person she admired most was her father. She's got a very idealistic view of her father and desires to have a very much easier warmer relationship. (Deborah's mother)

Deborah's attitude towards her father was also observed. She looked at him frequently during the time the family were seen together and moved to sit closer to him on two occasions when other family members moved. He, however, directed very little obvious attention to her.

Lack of physical closeness was a feature of the distance that existed between fathers and anorexic daughters. Deborah's father was apparently physically much more at ease with her

sisters. Teresa felt that she had always rejected her father physically. Barbara stated that after being raped she did not like to be in the same room as her father. Sarah's father thought he had shown her less physical affection since puberty:

> I suppose really, um, I was probably more conscious of it myself [difficulties with communicating love physically] when she was more developed. Since high school I probably didn't show her the same physical love.

Mothers. The subjects were clearly much closer to their mothers than their fathers. Elizabeth and Barbara felt that they were the closest children to their mothers. Deborah's mother recognized the special link between them because of Deborah's deafness, which resulted from rubella contracted during pregnancy.

The closeness however appeared to lead to a certain confusion as to whom feelings belonged to. Sarah's therapist recorded a "pain in the neck" which Sarah remarked on and which her mother said she had too. When Sarah went into hospital her mother said she would like to have crawled into her bag and gone too. Elizabeth referred to vomiting in two contexts, not specifically to do with the anorexia. When she was made to drink salt water by her father to make her sick, "My mother, who has a very sensitive stomach says she vomited for me". And listening to her parents arguing at night, which made her mother ill:

> I can remember so many nights knowing she was in the bedroom with a cold compress on her head and hearing her get up and go into the toilet and vomit. And I .... ugh! It left me weaker than it left her because I think I was vomiting for her probably. (Elizabeth)

The subjects perceived themselves as being the most perceptive as to their mothers' feelings and the mothers too saw these daughters being the most likely to notice when they were upset, although they were not necessarily the most likely to do something helpful as a result.

It was clear from the mother/daughter relationships of the two who were still anorexic, Deborah and Karen, that they were used to their mothers' thinking and acting on their

behalf. When her mother entered the room, Karen became considerably move passive and moved to a position sitting on the floor, where it was easy to exclude her from the conversation. Several times during her interview, Deborah responded to questions about herself by saying that the best person to ask would be her mother. Sarah's mother reported how Sarah had been very reluctant to make any decisions for herself when the two of them had been on holiday together. Sarah had exhibited the same dependence in refusing to stay at university away from home.

Mothers appeared to take their home-making role and cooking seriously. Sarah's mother, in addition to describing her anxiety about feeding her children properly as babies, said, "I've always been very conscious of the family having the right intake of food, a good balanced diet". The friend of Sarah's family had noticed how when out for a meal all the children had looked to their mother to decide what they should eat. Her perception was that this kind of behaviour was more appropriate for much younger children. Barbara's mother described herself as a good plain cook and her husband said she "kept a good table". Elizabeth's mother had "a two or three year apprenticeship" in pastry-making from her mother-in-law before marriage. In Elizabeth's family, however, it was the father who was meticulous about food, but the mother "obeyed". Food seemed an important part of Deborah's family, at the meal attended by the researcher food seemed highly valued and a wide variety of dishes were served for individual family members.

Mothers appeared to be intelligent and ambitious women, possibly frustrated in their careers. Barbara's mother had done clerical work and some nursing. Karen's mother was involved with her husband in running a retail business, Deborah's mother had been a nurse and Sarah's was a teacher. The therapist in Deborah's case said of her mother:

> I think that probably to a degree she does strike the frustration of a highly competent intelligent person. (Deborah's therapist)

Mothers were perceived as being somewhat over-anxious. Deborah described her mother as "panicky-natured" and the therapist described Sarah's mother as "a very anxious lady".

Both of these mothers felt that the anorexia indicated a failure on their part and tension was obvious in both women, as also in Karen's mother who was highly defensive about her daughter's problem and seemed anxious to find a cause for it that was not connected with herself.

The Spouse Relationship. The most noticeable aspect conveyed of the spouse relationship was the dominance of wives over husbands. In the three families where husband and wife could be observed together, wives spoke with much greater ease than their husbands and had a tendency to interrupt them. This was particularly noticeable in Sarah's family where during the joint interview the wife drew her chair nearer and nearer to the researcher while the husband gradually withdrew his. It also appeared that some of the important decisions with regard to Sarah's anorexia had been taken when the father was away on business. The parents to a certain degree were aware of the pattern of the relationship. Sarah's mother said, "I seem to do all the talking". Both parents had been to an assertiveness course at the hospital's recommendation, but it was made clear to the researcher by parents and therapist that it was the father who needed it.

The contact was too brief in each case to be able to explore the spouses' sexual relationships. The spouses appeared close however and the couples of the two large families (Deborah's and Barbara's) indirectly commented on sexual activity if not on sexual satisfaction. Parents had found the anorexia placed a great strain on their relationship:

> I hadn't realized until we got into this thing that a sick child can be a real bone of contention if one sees it differently from the other .... I remember thinking that parents need an awful lot of help not just with the child but with each other. (Deborah's mother)

Siblings. Most of the information offered centred on sisters rather than on brothers. Sisters, like mothers, were very close to the subjects and this involved ambivalent feelings. Elizabeth felt that she still had a very close relationship with her older sister which had developed during adolescence. They had travelled together, become religious converts, dieted and had their tonsils out together. Elizabeth commented

that other people thought the relationship abnormal and disapproved. Sarah had been close to her younger sister, but the anorexia had brought a lot of tension and disagreement into the relationship:

> We're certainly not as close as we have been in the past. In some ways that's a good thing because we were a little bit too close, I think. (Sarah)

Closeness, leading to competition, jealousy and argument were also the case for Barbara and Deborah with their sisters. Both Sarah and Deborah had become keen to see their sisters gain weight.

The whole family. Families were mainly what could be regarded as middle class, only Barbara's family was clearly not so. All the families seemed ambitious. Both Deborah's family and Sarah's were described as being "perfectionist". "Close" was another adjective used by families to describe themselves, and this was sometimes paired with the notion of being isolated socially. Elizabeth's family were isolated by their religion, politics and approach to health, and others just communicated a general separateness.

Lack of differentiation between siblings was also evident in some cases. For their first session with the therapist, Deborah's mother had dressed the three youngest children identically and they were mistaken by several people for triplets. Sarah's family had been encouraged to differentiate more between the three children by a psychologist:

> She suggested that it would be good if Sarah be allowed to stay up later than the others, do a few more things than the others did, which we hadn't really seen as necessary because I suppose we did everything together and everyone had seemed happy doing things that way. (Sarah's mother)

Mothers played the central role in the total families. Sarah's mother described herself as the buffer between others during the anorexia. Barbara felt quite happy about the researcher interviewing her mother but thought her father would not want to be involved and would have nothing to contribute. When the writer went to the house, it was obvious however that he was anxious not to be excluded. Observation of Deborah's family also indicated that the household revolved

around the mother. In Karen's family, although the father was not interviewed from the pattern of statements the mother appeared to be the person most usually referred to over family matters.

Finally, the anorexia was clearly a source of great stress in the family. Deborah's mother commented on the way it had upset all the children and deprived them of her attention. Sarah's mother commented on how much happier and freer they were as a family when Sarah was not at home. This especially related to the arguments Sarah seemed to cause.

Theme Three - The Extended Family

This theme emerged as of some importance in relation to three of the subjects whilst for the others, it did not appear important at all.

For Deborah, Elizabeth and Sarah the extended family, particularly grandparents had been an important influence in childhood. When Sarah's family moved several hundred miles away from them when she was nine, it caused both Sarah and her mother great stress. Sarah's mother thought that it marked the beginning of the breakdown for Sarah. Sarah remembered nightmares from that period and wanted to be close to her mother all the time. Her worst fear was that her great grandmother would die:

> It was like she was holding me on to something .... To keep me to what I really cherish. (Sarah)

Both Sarah's mother and Elizabeth's were themselves raised by their grandmothers because their mothers had to work as their fathers had died. The women in these families appeared ambitious and dominant. Sarah's mother talking about her own childhood said:

> If Mum tried to assert any authority I think Granny took that away from her really. But then Granny really was an over-ruling person because when I left school and could have gone to Teachers' College, I wasn't allowed to. She said she'd sit down and die. (Sarah's mother)

Sarah's father's family was also very close emotionally and both sides of Elizabeth's family had frequent contact with them. She felt that in her father's family the women were very much the "prisoners" of their men. Interestingly her

father's mother had digestive problems and was an invalid. For years her grandfather fed his wife the wrong food without realizing that this was making her worse:

> It's faintly sinister and it bothers me quite a lot to think that in a way my grandfather was slowly killing her. (Elizabeth)

Barbara's family, for example, were in direct contrast to this close picture. Her parents had moved first from Ireland to London early in their married life and, after her sister and Barbara were born, to New Zealand. The first move they said was for work purposes, the second to escape the pollution they experienced in London. Neither of the parents expressed any great regrets at leaving their familes. For Tania and Teresa, similarly, the extended family did not feature as being of any real significance.

Theme Four - Outside the Family

This section examines relationships outside the family which the subjects discussed. This included husbands and boyfriends, social life and friendships and relationships with older people.

As already described, Elizabeth had set very careful boundaries on her marriage in order to retain her separateness. Of the years between 18 and 24, the time when she had been at her lightest, she wrote in her autobiography:

> There were only one or two brief and shallow encounters with men for me .... my life was very full, satisfying and deliberately, delightfully manless.

Before this period she had had numerous boyfriends but, "apart from heavy necking, no-one was getting anything from me". Barbara was attracted to her husband because he was not sexually demanding, 'I thought 'Wonderful! The first time I've met one who doesn't lunge all over you'. Previously she had dropped boyfriends immediately they started wanting sex with her. None of the other subjects had current boyfriends. When Deborah was asked how old she thought she would be when she first would have a boyfriend, this interaction occurred:

> Deborah: Um, I don't know. Seventeen?
>
> Researcher: That's not far off. [She was 16½ years old]

Deborah: Make it eighteen!

In relation to the choice of partner both Barbara and Elizabeth had married into families where food was important. Barbara's husband's family appeared close from her descriptions and his mother very involved in her 'home-maker'role. Elizabeth's husband and brother-in-law worked in catering, her sister-in-law had been anorexic and her mother-in-law occasionally used self-induced vomiting as a means of controlling her food intake.

There was some evidence of a dependence on relationships with older people outside the family. Barbara's mother commented on her daughter's friendship with an older woman which she had thought strange. Teresa appeared quite dependent on an older man at work whose opinion she consulted about non-work issues. Sarah had had a very important friendship with a teacher who had, by mutual definition,played a father role in her life. When asked how he felt when he visited her in hospital, he said:

> I wanted her to be one of mine (children) and get better .... I thought of her as about the same age as my own children, small and fragile which she was. (Sarah's teacher)

The religious sect may have met a dependence need for Elizabeth. Barbara had married a man seven years older than her.

> But he is a very older older, you know .... I suppose I saw the elements of his caring, looking-after nature, just like Dad, when I met him .... [Later] I just found it intolerable, him ordering me about and treating me like a child.(Barbara)

Some of the subjects had numerous peer relationships, some did not. Barbara's diary indicated the wide range of friends who visited her while she was in hospital and she also made many friends within the hospital. She appeared to end friendships rather abruptly sometimes however. Karen's friends seemed to be moving away from her as they became frustrated by her implacability about not eating. Elizabeth remembered the period of her anorexia as being a time when she and her sister were rather isolated. Deborah's leisure activities, ballet,playing the piano, the violin and the guitar meant she

spent much time on her own. Tania, Teresa and Sarah had few friends and Sarah reported finding it difficult to make new ones:

> I'm quite happy on my own and I'm used to being on my own a lot. Perhaps that's one major fault I've got I think. (Sarah)

One significant aspect of the subjects' relationships with others was that in every case anorexia had developed at a time when each had moved into a new setting and were faced with new contacts. For Deborah it co-incided with the move to high school, particularly difficult for her since her hearing difficulties meant major adjustments after the little one-teacher school she had been in. Teresa's anorexia also began in her third form year. For Karen, Tania, Barbara and Elizabeth it co-incided with leaving home for new social situations. Barbara's weight loss at 18 years old had not been sufficient to attract attention at that stage. Her additional weight loss occurred when she went overseas after her marriage and she saw these two events as having precipitated her illness. Sarah had moved from one large city to a smaller one over a year before the anorexia but since both she and her family dwelt at some length on this move and on the previous one when she was nine, it can be assumed that it was regarded as significant.

Summary and Discussion: Self and Others

Passivity and withdrawal are elements of anorexia nervosa noted in the literature and it was suggested that these elements became worse as weight loss became more serious. Withdrawal was also seen to entail suppression of feelings. The subjects in the study on the whole matched these claims. Deception, also highlighted in the literature and regarded as a complication in treatment, was in this group of anorexics related mostly to the determination to lose weight and was only really over the issue of eating.

Passivity as a concept can be seen as the inverse of power and represents one aspect of the control paradox in anorexia nervosa referred to by Lawrence (1979). The anorexic's passivity encouraged others to take charge but also may be used by the anorexic to subtly reject their attempts to

do so. Hence the frustration experienced by therapists and parents which emerges from the literature and which was experienced by the families in this study. It must be remembered that a refusal to eat has traditionally been used as a potent form of passive protest by individuals and groups who have perceived themselves as too powerless to influence their situation any other way. The ire aroused by the hunger strikes of the suffragettes, Mahutma Ghandi and recently the I.R.A. prisoners indicates how effective and frustrating such a protest may be.

The picture of the families which emerge in this study is somewhat similar to that elaborated in the family therapy approach and it could be presumed that the approach was most suitable for dealing with various family issues. Families appeared to be enmeshed and over-protective and there was a particularly close bond between mothers and anorexic daughters. Not all of the families seemed to avoid conflict, however, in two cases at least there appeared to have been considerable open conflict in earlier years. Nor was there any evidence to suggest notable marital problems between the parents, although contact with the researcher was probably insufficient for any disclosure of this. The researcher did not become aware of any unexpressed conflict, however, except perhaps in relation to patterns of dominance.

Women in the family; mothers, sisters and grandmothers, appeared to play a more central role in the anorexia. Indeed Selvini Palazzoli's (1978) perception of fathers as distanced was very much supported. Ambivalence about careers and home-making roles did seem to have been a feature for more than one generation, as were issues of dominance in the family.

Concerns relating to boyfriends and marriage suggested again a sexual component, possibly linked to fears of dominance. The finding of Crisp et al (1977) that relationships formed during the anorexia are unlikely to survive recovery was true for one of the married cases in this study. Both husbands appeared to come from families where some of the same 'anorexic' dynamics operated, again suggesting the appropriateness of family treatment, where the married couple may be regarded as the family.

The evidence obtained relating to relationships with older people suggests that anorexics may continue to search for parent-figures after they have left home and may use these to fill needs that fathers, in particular, have not met.

Finally, an emergence of the anorexia in relation to new social situations for these subjects was consistent. It could be claimed that insecurity in approaching these new situations may provide the impetus for the development of anorexia, in that it introduces a feeling of control where this is felt to be lacking.

Theme Category Four - Intervention

This category brings together issues which emerged relating to treatment. This includes consideration of the early stages of the disorder and its recognition, treatment and hospitalization, and treatment outcome.

Theme One - The Early Stages

Important questions to do with intervention are, how was the anorexia recognized and how early would it have been possible, or necessary, to intervene? Both Deborah's mother and Sarah's had heard of anorexia nervosa. Deborah's mother's younger sister had been anorexic and had stayed with Deborah's parents. Sarah's mother said she had read about the disorder. However it needed some unusual event for the problem to be recognized. Deborah's mother happened to walk into the bathroom while Deborah was having a bath and was shocked at how thin she was. Only after this did she start to notice the changed eating patterns. Sarah's mother realized when a family friend commented on the weight loss having not seen the family for some time. Elizabeth's mother became anxious when Elizabeth went home, for a visit. Karen's mother was still unwilling to recognise that a problem existed.

After the family realized Deborah was ill, the symptoms worsened considerably. Deborah became much more obstinate and ill-tempered and began spitting continuously in order to avoid swallowing her saliva, which her family found very

disturbing. Her mother felt guilty!:

> And I was shocked that she'd be so sick before we saw it. That was one of the hardest things to come to terms with. Here was I a registered nurse and a good mother, I thought, and hadn't even seen this. (Deborah's mother)

In Sarah's family the first signs were interactional rather than physical. Her sister said that the arguing had begun before they noticed the weight loss and at school she had withdrawn from people.

Sarah, when asked at what point intervention would have needed to occur in order to prevent the disorder developing thought it would have to have been very early, before the appearance of any major symptoms:

> Once I started shutting myself off the world started to look really ugly and everything and it was at that stage that nothing could really stand in my road.

Theme Two - Treatment

Five out of the seven subjects had received specialised treatment for anorexia nervosa. Karen had seen a specialist about her amenorrhea and her mother appeared convinced that this was the only problem although she was very defensive. Elizabeth never received treatment but had apparently improved spontaneously over time.

Sarah, Tania, Teresa, Barbara had been hospitalized. A common belief for them was that hospital was unpleasant but necessary. Tania received treatment on a medical ward. She said:

> I literally ate my way out of hospital. I realized the only way out was to put on weight. Actually I was much worse after I came out, but I wouldn't go back. (Tania)

She did not receive any psychiatric treatment and was grateful for this, seeing this treatment as involving a stigma. Although Sarah stated that the hospital was "like one big happy family", her mother thought that she put on weight quickly in order to get out. Her therapist thought the rapid recovery was due to her lack of deception after hospitalization and her only moderately distorted body image. Her teacher had had very negative feelings about the hospital after visiting her; it seemed impersonal to him. Sarah had initially been resistent

to being hospitalized, but after a crisis at home where she shut herself in the bathroom saying she had eaten her last meal, according to the therapist, "She came like a lamb". Barbara was initially distressed to find she needed a psychiatrist. She agreed to go into hospital because she was convinced she could not put on weight as an outpatient and knew she needed help. She perceived entering hospital as succombing to other people. The environment she described was very restricted. She had to remain in bed until she reached target weight, could only have a bath and wash her hair once a week, and had to use a commode in her room. In her diary boredom was mentioned frequently and the sense of giving up control of herself was strong. Patients were not given a choice of target weight and they were given a 3000 calorie a day diet, all of which had to be eaten. Barbara stated with unconscious irony:

> In fact it was a voluntary thing. If you weren't happy to be in there and eat what they gave you, it was 'outski'.

The most vivid illustration of the loss of control that appeared to be involved was that for ward rounds, when patients appeared before a panel of staff, they were wheeled on their commodes which also served as chairs. When target weight was reached however, considerable freedom was allowed including outings with friends for meals, providing weight was maintained.

All of the subjects in this study put on weight easily after treatment started. Deborah's mother said that for her it was because she was threatened with hospital if she did not increase her weight. Sarah put on weight without a behaviour modification programme, although her hospital usually used one. She remembered choosing to remain in her room in the early stages and gradually coming out of it as she improved and likened it to a shell she needed initially. Barbara obeyed the hospital's instructions because:

> I'd always had this tremendously rational side; I was there because I wanted to get over it. (Barbara)

Both Sarah and Barbara experienced physical discomfort. Sarah was given sedation which made her fear she was going

choke. This had to be discontinued. Barbara found the quantity of food caused her discomfort and she had frequent colic. After reaching her target weight, she damaged her knees in her enthusiasm to become fit and active again quickly.

Barbara and Sarah also commented on the difficulty of learning appropriate eating habits for the post-hospitalization period. Sarah found it difficult to adjust to having her main meal in the evening after the hospital midday routine. Barbara commented:

> I was amazed! One of the good lessons an anorexic needs to learn is how much food you actually need to put on weight.

Barbara's therapy involved individual psychotherapy with a woman doctor, occupational therapy which included 'Projective' art work and cookery, marital counselling, consultations with a dietician, and group work with other patients. Of her therapist she said, "It wasn't so much 'I'll tell you what to think' it was 'Oh, why do you do that?'" The sharing of her experiences with other anorexics in group therapy sessions and informally also appears to have been beneficial.

Sarah received individual and family therapy from the same therapist. She retained strong ambivalent feelings about this woman; on the one hand she had apparently made herself Sarah's ally and freed her from some of the battles she was involved in, but on the other she had from Sarah's viewpoint taken control of her and was therefore perceived as a very powerful person. Sarah's mother displayed the same ambivalence. Treatment had focused on creating greater distance between Sarah and her mother, strengthening the spouse relationship, including the father more in the family and helping him to be more assertive. Individual therapy considered issues raised in the family sessions and problems regarding dependence and independence. Relaxation, work on body image, and contact with the dietician were also included.

Deborah was not hospitalized although of all the subjects her weight was the lowest. Although their relationship with the family therapist who was currently treating them was very good, the family had experienced some negative situations

before being referred to her. Deborah's mother felt that she had been blamed in some situations and had felt powerless.

> He said things like 'Do you think you've got room in your family for this child?' Challenging things as if to say 'Now I've found the one you don't want'.

She also recalled with displeasure a situation where the doctor sat behind a large desk to interview them and students, called in to see them, stood round the walls. Deborah's mother felt responsible for the anorexia because she thought she had been too protective as a result of Deborah's deafness and this made such sessions very painful for her:

> I'd lie awake at night saying 'I wonder what he wrote down? I wonder if he wrote down - mother domineering and father something else?' I felt like saying 'Show me those records and we'll argue this one out'.

Finally the family was referred to the family therapist who initially saw them all together, although most of the subsequent sessions had just involved Deborah and her mother or her parents. The mother was impressed with the style of contact, "She never spoke to us about Deborah without her being there". The mother did however comment that she did not like the use of the one-way mirror, since she did not know what the people behind were thinking.

The family therapy used with Deborah's family had apparently worked to reorganize family structure and had redefined the problem: the family was a 'coping' family and Deborah did not feel like a 'coper'. It was interesting to note that in this case, as with Sarah's family, individual family members did not see themselves as directly involved in the therapy itself. Deborah's sister remembered that the children had participated very little because they felt shy and Deborah's mother adopted an observer's role, saying "She got everybody going. I quite enjoyed watching it myself". Nevertheless family therapy was perceived by both families as useful, Sarah's sister thought they all got a lot out of their "systems", and Deborah stated, "I think she's helped Mum with her guilty complex".

Theme Three - Outcome

The extent to which aspects of the anorexia remained

important in the subjects' lives has already been discussed in several places. In relation to food, it was found that the subjects still found that they were not easy about their attitudes to it and their eating patterns, it would appear that close relationships might still be problematical and exercise was still important.

Karen and Deborah were clearly not recovered. Karen expressed a determination to put on weight, but whether this would be maintained must at this stage be extremely doubtful. Deborah thought that it would probably be another year at least before she was recovered. Her therapist thought two years was likely. Her sister said however that she was considerably less fussy than she had been and her mother thought she would be recovered when she menstruated.

Sarah was very isolated and over-involved in food, and still commented on her sister's behaviour. Her weight appeared somewhat unstable and was increasing. Her fear of returning to sporting activity also suggests this area may not be resolved. The parents thought that there remained considerable strain in the family with Sarah being very adamant about her rights. According to her mother, "She's really screaming out for attention but there's still that communication block". The therapist thought that the return from university was a bad sign as it suggested that Sarah was still over-involved with her family. An important factor in Sarah's family was that in the last few months, her mother had felt very stressed and had finally given up work. She had been seeing a therapist herself. This was portrayed to the researcher as being mainly about how to handle Sarah, whereas the therapist indicated that this was not strictly true. Sarah's sister indicated that there had been fears that the mother was herself anorexic.

Contact with Tania and Teresa was not altogether extensive enough to arrive at any substantive conclusions as to the outcome of their experiences. Both seemed slightly anxious still about their eating, both were somewhat shy, lacking in confidence and appeared quick to seek and respond to the opinion of others. They were both also rather isolated and unattached.

Elizabeth and Barbara seemed to have arrived at some workable compromises. Elizabeth's seemed likely to be less flexible than Barbara's. She had organized her life so that her sense of control could be maintained in her marriage, her eating and her relationships with others. Although she regretted the loss of her efficiency, "I've gotten very lax over the last few years". She still lead a very organized life and demanded much of herself. In relation to the fat, incompetent, lovable self she feared, she said:

> Being aware helps achieve some balance, but it doesn't send the creature away. (Elizabeth)

Barbara thought she had gained from her experiences as she could have "tottered along on the fringe of anorexia for the rest of my [her] life". She said that the same thought patterns occurred from time to time and she still had high standards, but her ambition was under control now and she was more free and easy. Her father too saw her improvement in terms of control, "She seems to have a better grip now". Barbara thought that she was never likely to become overweight but she was not the best person to judge her weight and so she had two friends who were detailed to let her know if she was to get too thin. She said:

> I think the parallels between anorexia and alcoholism are very real and I think if you have the potential to become anorexic, just because you've got over it doesn't mean you're totally cured.

Barbara in fact voiced, quite poignantly, the very concerns which had served to motivate this study.

> It's very difficult to draw the line between what's anorexic behaviour and what's not .... I've got friends who are just as weight conscious, if not more and this is what confuses me. What made me what I was and what makes them not trip over?

Summary and Discussion - Intervention

It is evident that any attempts to identify anorexia nervosa in the early stages are complicated by its gradual emergence, making it very difficult to recognize even for those close to the individual concerned. In addition since the key diagnostic factor is a 25% weight loss, the disorder is unlikely to be diagnosed until late in its development. With hindsight one family recognized that they were aware of

emotional changes before the physical ones became evident. If, as implied then, any intervention to prevent its development needs to occur before the anorexic has started to withdraw and lose too much weight, then the possibilities of achieving that look unpromising at present.

Subjects had negative or ambivalent feelings about hospitalization and Agras and Werne's (1977) finding that discharge from hospital was an important reinforcer for weight gain seemed well supported. Medical personnel are often unaware of how negatively their everyday environment is perceived by the populace in general and this is perhaps particularly true in the area of psychiatry. Moreover any hospitalization is likely to involve a loss of self control and if, as has been previously suggested and certainly has emerged clearly from this study, issues of control are central in anorexia, then hospital environments are likely to be perceived very negatively by anorexics. Those connected with the anorexics had also had unpleasant contacts with medical personnel and had felt that their particular feelings had been disregarded.

Weight gain had been relatively easy for all the subjects in this study and this supports Hsu's (1980) suggestion that weight gain is not the main problem in treatment. The determination to get better seemed to have been the critical factor, rather than the type of treatment. Most subjects had received mixed treatments, although in each case a major orientation was evident. This made it very hard to identify which aspects might have been the successful ones with these cases. Subjects tended to discuss aspects of the major orientation in detail and to mention other aspects only in passing. Neither therapist interviewed found the mixture of treatment modes difficult to handle, in fact both appeared surprised by the suggestion that this might be problematic. The review of literature suggested that the more searching the investigation and the more long-term the follow-up of outcome, the more depressing the results were. This picture was supported by the results in this study. Numerous aspects of the disorder were still clearly evident in the subjects, although not necessarily in a way that was incapacitating or

seriously hindering to them. On broad criteria they could probably be regarded as having successfully overcome the disorder and indications are such that this could reasonably be associated with joint elements of treatment and of spontaneous remission. However, in more precise focus, each was still very much entwined within the disorder and seemed to be maintaining a relatively strong yet slightly precarious point of balance.

CHAPTER FIVE

S U M M A R Y A N D C O N C L U S I O N S

This Chapter firstly summarizes the major findings of the research. The limitations of the study are then discussed and suggestions made for further research. Finally, some concluding statements draw together this consideration of anorexia nervosa.

Summary of Findings

There were several findings in this study which supported perspectives on anorexia nervosa which had been evident in the literature.

There appeared to be support for a sexuality component to the disorder, illustrated in the main by subjects' attitudes to their amenorrhea and by concerns about particular parts of their bodies, lack of confidence in their own sexuality and an apparent reluctance to engage in long-term close relationships with men. The major perspective which emerged supported that aspect of the psychosexual stance which suggested that anorexia nervosa was an avoidance of adult female functioning as well as the ego psychological stance which perceived the disorder as an attempt to sustain uncertain ego boundaries. It could also perhaps be described and explained in terms of role conflict issues, with there being some reluctance to adopt an inferior social position symbolized by traditional male/female relationship concepts. This latter perspective is aligned to contemporary feminist positions and has only relatively recently been promoted as a way of reconsidering the dynamics of various psychological disorders.

Depression and suicidal thoughts, noted in the literature of all three treatment approaches and particularly stressed by psychodynamicists as a possible consequence of inappropriate treatment methods were found to have existed in these subjects prior to treatment. These symptoms appeared to be related much more to a poor self concept, a feature which emerged as particularly central in this study. Self concept too was consistently acknowledged as important in other studies on the disorder.

Subjects perceived their non-eating as personally

rewarding and attention seeking in the way that they perceived all success as bringing them attention. This is aligned with the behavioural perspective and supports the belief that behaviourism can be successful with anorexics provided the appropriate target behaviours and reinforcements are determined. The achievement orientation may serve as a strong motivation for recovery, but its dynamics are likely to be intricately intertwined with family operations and considerable sophistication is likely to be necessary to be able to unravel the appropriate stimulus-response patterns and reinforcement contingencies.

The pattern of interpersonal interaction during the anorexia which emerged from the study was very similar to that suggested in the literature. The passivity which was evident in the data from the subjects highlights to some extent the theme of control which runs throughout the descriptions of treatment. This aspect is particularly complex and hard to deal with in that it encourages yet frustrates external control. It is therefore very likely to be a complicating factor in both interpersonal dynamics, especially those of the family, and in treatment itself.

The findings with regard to family functioning seemed to largely confirm those described in the literature relating to family operations and therapy. Families appeared in particular to be enmeshed and somewhat overprotective. There was some slight evidence of rigidity in relation to not allowing change to occur in families. Conflict avoidance however did not seem to be evident overall, at least in the areas of family functioning accessible to the researcher. There was some support also for the likely influence of the extended family on family dynamics relating to the disorder, and a recurrence of generational themes, such as those of dominance and ambivalence about female roles. Restructuring of the family system would seem to have far-reaching value in these kinds of circumstances in particular.

There were clear indications of the existence of multi-faceted treatment programmes in relation to the anorexics, a feature obvious from the responses of the subjects but also from the descriptions by the therapists. This

circumstance is in line with much of the recent literature on the treatment of anorexia nervosa and it is not clear as to whether it is necessary as a way to deal with the wide variety of symptoms and likely causes, or whether it represents something of a 'shotgun' approach to treatment hoping that something will hit the mark. There did not appear to have been any great conflict for the subjects or their therapists about the different philosophical and procedural perspectives which might be involved. However it was interesting to note that subjects tended to concentrate on one treatment mode in detail and to only mention briefly any other treatments employed. This pattern was also evident from the literature.

In line with more intensive and searching studies on outcome, it could not be said that the anorexia nervosa subjects had recovered completely from the disorder. Rather, they had appeared to arrange somewhat sophisticated compromises which minimized any disadvantages for themselves. In particular, food, exercise and interpersonal relationships still showed clear evidence of anorexic concerns.

Certain contentions found in the literature were specifically not confirmed by the data collected in this study. There was no firm evidence to suggest that earlier feeding patterns were involved in the disorder, nor was there any consistent weight pattern in families. Bulimia and vomiting did not seem to be related to the severity of the disorder nor did they necessarily seem to occur more after treatment.

The denial of the disorder, which in the literature is mostly linked to body image, was not as extensive in these subjects and seemed to be mainly aimed at persuading others that there was nothing to be concerned about. Subjects seemed to have been aware that a problem existed for them, and also they were aware of actually being thin.

Some major findings which emerged from the study were not given the same prominence in the literature or when addressed were considered in a somewhat different way. The most significant of these was the issue of control which appeared to be a central recurring and widespread concern of the subjects in this study. Its combination with a poor self concept appeared to result in a determination to obtain

control of hated aspects of the self which were crystallized mainly in appearance and bodily function issues. To a certain extent this picture is similar to that suggested by the ego psychological stance in the psychodynamic approach, which suggests that the problem relates mostly to poorly identified ego boundaries. Here however a strong suggestion that emerged was that this internal process was also likely to be stimulated by and manifest itself in the social position of anorexics (who are mainly women) rather than as individual defects in personality functioning. Thus the confusions often experienced between the ambitious self and the home-making self, between the desire to control one's environment and the desire to give oneself to serving others may result in conflicts that are dealt with in terms of trying internally to control and overcome the despised, inadequate self. Issues concerning exercise, vocational choice and attitudes to treatment may also be seen in this context. In addition the reliance on relationships with older people which was found could be regarded as an aspect of continued dependence on family figures and a reluctance to see the self as an independent functioning adult, as well as part of having a poor opinion of the self.

Vocational choice, which is not dealt with in the literature, indicated some interest in areas of food and bodily functioning, but the most striking feature was the consistent preference for welfare-type work which demanded tertiary study. This preference may be seen as providing some compromise between strong ambitious drives and movement towards traditional female roles. The continued importance of exercise for the subjects was noted and there is no clear reference to this pattern in the literature. It suggests that the over-activity evident in the syndrome does not necessarily disappear with recovery in terms of weight and may be indicative further of the strong and ongoing emphasis on bodily control inherent in the disorder.

Attitudes to treatment itself, as might be expected in a study which considered subjects independent of any treatment programme or setting, provided something of a new perspective. Subjects had very ambivalent feelings about treatment. The recognized that they had needed help but

disliked the real loss of control this entailed for them. Some individuals felt they had been treated very insensitively in various situations, especially in hospital. A preference for outpatient treatment seemed the most likely to find favour therefore, although hospitalization usually had an immediate impact. In addition it would seem that attention needs to be given to the rights and the feelings of clients and their families whatever the treatment approach. The recognition that there seems to be that power, self control and control by others is central should be considered in terms of the philosophies of the various treatments but especially should be evident in all their procedures.

Limitations of the Study

A number of potential limitations can be recognized for this study. Because of the wide-ranging nature of the issues considered and the in-depth exploration of individual experiences necessary, the number of subjects involved was inevitably small. In addition the flexibility required with the method used meant that the range of material collected from individual subjects would probably differ, and gaps might occur despite early and ongoing consideration of material and themes to be pursued. Efforts were made to minimize this but it is not always clear where this might be happening. The results therefore must be seen as offering more the beginnings of a process of discovering new understandings of the syndrome, with the findings which have been identified here needing to be tested in more controlled and structured studies using larger samples.

The subjects who participated in the study were all quite willing to participate and talk about their experiences and these features must to a certain extent be reflected in the results. Those prepared to co-operate in this way are more likely to have reached some resolution of their feelings regarding the disorder and perhaps be more articulate, thus they may not be totally representative of the disorder and especially more seriously affected cases.

Because most of the subjects were considered retrospectively, their closeness to the disorder and their level of

sophistication about it could be questioned. Also their perceptions were inevitably influenced by the treatment approach they experienced. It was for this reason that a range of treatment experiences and settings was sought, and efforts were made to pursue wider perspectives within the interviews.

The case study method and a phenomenological orientation offers a number of advantages in exploratory research frameworks. It must be acknowledged, however, that their ideographic nature is bound to involve selectivity, and subjectivity on the part of both subjects and researcher is the essence. This feature represents both a strength and a weakness in the approach; a strength in that it taps perspectives that are likely to be overlooked in other methods, and a weakness in that it is difficult to prevent some bias and to obtain consistently reliable data.

Suggestions for Future Research

Future research should examine the findings of this study with larger groups of anorexics and with those whose experience of the disorder is more severe. In particular the relationship between control and self concept merits further investigation in the hope of eventually being able to diagnose the disorder at the beginning stages of its development so that earlier intervention may avoid some of the physical and psychological damage which results from the condition over a long period.

Further outcome studies should consider the nature of the long-term adjustments made by anorexics to the ongoing elements of the disorder, as well as considering broad, yet precisely defined, physical, emotional and social recovery criteria. This might not only indicate some directions for treatment but also help identify features of the disorder as yet unclear in the literature. A phenomenological approach to the experiences of treatment of other psychological disorders might allow valuable comparisons about the impressions created by treatment settings and contribute to the understandings of the process of recovery from anorexia nervosa. Too often it seems factors operate which are out of the awareness of the treatment personnel. Finally a psychosocial perspective on female mental disorders in general

which is beginning to emerge should be applied to some anorexia nervosa reseach studies, for it is here that the key may be found to an apparent increase in incidence and lead to important new perspectives on etiology and treatment.

Conclusions

In returning to the original research questions as to the nature of anorexia nervosa as experienced by a small group of subjects and the applicability of the various theoretical approaches and their consequent treatment frameworks, no one approach to the disorder has shown itself to provide a completely comprehensive set of understandings.

In exploring the nature of anorexia it was found that matters of control and self concept appeared central to the disorder to an extent that was not previously represented. It was also found that aspects of the syndrome were still present even though in general terms the individual might be said to have recovered. Issues concerning the role of sexuality in the disorder and ambivalence about the adoption of traditional female roles were also evident.

The strength of the psychodynamic approach to anorexia nervosa appears to be in its recognition of the importance of establishing boundaries for the anorexic as stressed in the ego psychological stance. The psychosexual stance recognizes the dilemmas regarding female sexual behaviours for the anorexics, but its somewhat traditional view of 'normal' female functioning needs to be viewed with caution in a changing society. The great weakness of the psychodynamic approach appears to be the tendency to take control of the anorexic in treatment and to ignore the social settings in which the problem has been generated.

The behavioural approach offers a valuable perspective on the nature of reinforcement for the development and maintenance of anorexic behaviours. Its weakness seems to be a tendency to concentrate on narrowly defined and the most readily observable behaviours in the syndrome. In addition, despite affirmations to the contrary the behavioural approach is also most likely to be perceived by anorexics as taking control from them. More comprehensive target behaviours

need to be identified and more attention paid to patient perceptions of reinforcement programmes and to real-life contexts for generalizing treatment benefits. The developing interest that is apparent in other aspects of this disorder beyond eating and weight gain should improve the applicability of behavioural techniques.

The family therapy approach offers the opportunity to explore and influence interpersonal issues concerning control in the most critical setting in which they occur. The recognition of the family as having the problem is helpful in gathering powerful resources together to deal with it and offers opportunities to break up perpetuating patterns. The danger is that an emphasis on the family as the locus of the problem may ignore wider social factors in the incidence of anorexia nervosa, and may delay alterations in some of the individual dynamics of the disorder and its associated effects laid down often over a prolonged period.

It would seem overall that each approach has something unique to offer in the understanding of and treatment of this serious disorder, even though there is a great deal yet to know and apply. An important principle that may need reiteration, however, is that in successful psychotherapeutic treatment each case is regarded as unique and efforts must be made to go beyond prescribed frameworks - something that is not always apparent in existing work.

A P P E N D I X

An Outline of the Data Collection Experience with One Subject

The researcher first heard about Sarah from a friend of Sarah's family who was also a colleague. The researcher had been having a general discussion about her research intentions. Sarah had been formally diagnosed and treated as a case of anorexia nervosa. An approach was made through the friend to see if Sarah would be prepared to talk to the researcher about becoming involved in the study. Sarah agreed to this. She was then telephoned to arrange an appropriate time and she was asked where she would prefer to meet with the researcher. She expressed no preference, so the researcher suggested she visit Sarah at her home, and a convenient time was arranged.

The first session took place in the lounge. The purpose of the study was conveyed, avoiding as much as possible the use of the term 'anorexia nervosa', 'difficulties with eating' being used instead. The intention here was to avoid the creation of a medical or psychiatric atmosphere. Sarah was assured that if she agreed to participate, her identity would remain protected. She readily agreed to be involved, stating she did so for two reasons - to help others with similar experiences and because she thought it would be good for her not "to bottle things up".

Because of the opportunity and as the researcher was prepared for the eventuality it was readily agreed to conduct the interview at that point. A discussion ensued which lasted about two hours. Sarah discussed her experiences fully and at length.

At the end of this session another was arranged and Sarah was asked if she would mind other members of her family who were clearly involved (mother, father, sister) being interviewed. This she agreed to and also agreed to ask them if they would be prepared to be seen. The researcher then returned to her home and made notes of her observations during the session and reviewed the taped material.

The next individual session took place in the family

room at Sarah's home. Topics not covered in the earlier session (e.g. menstruation and induced vomiting) were introduced and elucidation of some issues raised in the first session was sought.

The first interview had involved collecting information about the present first, then exploring the period of the anorexia and finally dealing with the period before the anorexia. It was thought that talk about present circumstances would enable Sarah to relax and ease into the interview. This did not prove to be the case. She was more wary of questioning about the present, perhaps suspicious that her answers might betray to what extent she was not recovered. For later interviews it proved easier to begin with the declared area of interest, the period of the anorexia, work backwards from that into childhood and only lastly to cover the present.

In the course of these two interviews and two brief telephone talks with Sarah, it became apparent that the involvement of her therapist and one particular school teacher was particularly important to her. She was thus asked if she would give her permission for these people to be interviewed as well, which she did. There was then a period of non-contact while other cases were explored. When Sarah was contacted again she herself resisted any additional interviews, saying that she had decided she had "finished with all that, and anyway had forgotten most of what happened". She agreed however to write to the therapist and the teacher giving her permission for them to discuss their involvement with her. Somewhat more reluctantly at this point she agreed to follow-up the plans for her family to be seen.

The next interview was with the teacher in his office at school, followed by one with the therapist at her place of work. Finally interviews were conducted with the parents together and then separately with the sister. These latter interviews took place in the lounge at their home. During these sessions the researcher was offered lunch and accepted the invitation. All in the family, except the brother, were present at this time.

Sarah had earlier been asked if she had any diaries,

letters or drawings from the period of the anorexia, which she did not. Topics and themes, such as moving house, success at school and Sarah's relationship with her sister began to emerge early as the data from Sarah was collected and examined. These were taken up with other individuals connected with her. Finally all the material relating to Sarah was brought together and considered as a whole to establish the themes for her case in totality. This material overlapped with data collection and analysis procedures with other subjects and those closely connected with them.

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