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A Critical, Review of the Literature Dealing with Current Psychological Approaches to the Treatment of Anorexia Nervosa

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A CRITICAL REVIEW OF THE LITERATURE DEALING WITH CURRENT PSYCHOLOGICAL APPROACHES TO THE TREATMENT OF ANOREXIA NERVOSA

by

Pamela Jane Goy

A Thesis
Submitted to the
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of the
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I would like to express my deepest gratitude to Professors Christopher Koronakos and Frederick Gault for their advice, encouragement, and assistance in preparing this thesis. Although their aid facilitated the completion of my thesis, I am, nonetheless, solely responsible for what is written here.

Pamela Jane Goy
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>HISTORY OF THE CONCEPT OF ANOREXIA NERVOSA</td>
<td>3</td>
</tr>
<tr>
<td>THE PRE-MORBID PERSONALITY &amp; PRECIPITATING FACTORS</td>
<td>9</td>
</tr>
<tr>
<td>DIFFERENTIAL DIAGNOSIS</td>
<td>16</td>
</tr>
<tr>
<td>THERAPEUTIC CONSIDERATIONS</td>
<td>23</td>
</tr>
<tr>
<td>CURRENT MODES OF TREATMENT</td>
<td>27</td>
</tr>
<tr>
<td>PSYCHOTHERAPY</td>
<td>29</td>
</tr>
<tr>
<td>ATYPICAL PSYCHOTHERAPEUTIC TECHNIQUES</td>
<td>40</td>
</tr>
<tr>
<td>BEHAVIOR THERAPY</td>
<td>49</td>
</tr>
<tr>
<td>FAMILY THERAPY</td>
<td>59</td>
</tr>
<tr>
<td>SUMMARY</td>
<td>67</td>
</tr>
</tbody>
</table>
INTRODUCTION

The purpose of this paper is to review the literature dealing with current psychological approaches to the treatment of anorexia nervosa. Secondly, a critical evaluation of each therapeutic approach is undertaken, with special consideration given to the clinical factors which may facilitate or impede its effectiveness in treating anorexia.

The syndrome of anorexia nervosa has been the object of medical and psychiatric investigation for the past two hundred years. Descriptions of the disorder have remained highly stereotyped throughout this time period. Individuals suffering from anorexia are predominantly female, between the ages of ten and twenty years, who display an extreme aversion to food. The accompanying physical symptoms are cachexia, bradycardia, amenorrhea, and lowered blood pressure. No physiological pathology is present, the syndrome is psychologically determined.

Since anorexia nervosa is a fairly rare disorder, many people do not have knowledge of its occurrence, or of the physical and psychological factors which it involves. This paper is written to give the reader a basic understanding of
the phenomenon, and to familiarize him with the diverse therapeutic approaches which are currently used in its treatment.

It should be noted that no effort is made, within the scope of this paper, to differentially evaluate the male anorexic. Most of the reviewed studies involved a predominantly female population. It is this patient population to which the focus of this paper is directed.
HISTORY OF THE CONCEPT OF ANOREXIA NERVOSA

The concept of anorexia nervosa was first described in the medical literature in 1689, by Richard Morton. He referred to a state of nervous consumption in which the patient underwent progressive wasting and loss of appetite with no signs of cough, fever, or dyspepsia (Ushakov, 1971).

The first systematic study of the syndrome was initiated almost two centuries later, in 1873, by Charles Lasegue (Bruch, 1973; Ushakov, 1971; Goodsitt, 1969; Thomae, 1975). He referred to eight patients suffering from what he called "anorexia hysterique." Lasegue's classical description of the disorder noted the presence of severe weight loss, rejection of food, amenorrhea, and constipation in his patients, as well as the absence of somatic pathology. He further delineated three stages in the course of the hysteria. The first, or "gastric stage (Ushakov, 1971)" involves the patient's initial refusals of food, due to complaints of stomach pain while eating. This is followed by a "struggling stage (Ushakov, 1971)" at which time the patient's sensations of pain disappear.
individual then equates his starving behavior with health.

Lastly, extreme emaciation occurs during the "cachetic stage" and weakness confines the individual to bed (Ushakov, 1971).

Gull, in 1874, reported similar findings, and attributed his patient's lack of appetite to a morbid mental state (Goodsitt, 1969). He coined the term "anorexia nervosa" which was then adopted, and is still in use in English, Russian, and German medical literature (Bruch, 1973; Ushakov, 1971).

Since the initial reports of anorexia nervosa, the syndrome has been the object of innumerable systematic studies despite its apparent rarity. It is interesting to note that in the past one hundred years, reports of the symptomatology remain highly consistent. Most clinicians repeatedly note the presence of the syndrome in a predominantly female population between the ages of ten and twenty years. It is characterized by a strong aversion to food, resulting in severe weight loss, cachexia, amenorrhea, and constipation (Rowland, 1970).

Although the somatic picture of the disorder has not been subject to change over the years, concepts regarding etiological factors have undergone many changes (Bruch,
In the earliest literature, anorexia nervosa was viewed as a brain disturbance or some form of mental malfunctioning. The advent of Laègue's concept of hysteria then introduced the notion of an inherited degenerative disorder (Bruch, 1970a). Gull's interpretations of anorexia nervosa as being caused by some form of mental stress is comparable to a number of contemporary psychoanalytical interpretations.

Until the early 1900's, it was generally agreed upon that anorexia nervosa was a psychogenic disorder. However, as more studies were completed, the clinical picture of the syndrome became more confused. In 1914, Simmond, a pathologist, reported the discovery of destructive lesions in the pituitary gland of a woman with marked emaciation, who had died following pregnancy and delivery (Bruch, 1970a). This caused a total change in the approach to any form of malnutrition, attributing the cause to disturbances in the endocrine system. Thus, the concept of anorexia nervosa was further confused, with no clear agreement on what was included within that concept. The theory of endocrinological origin of anorexia nervosa persisted in the United States into the 1930's, and longer in Europe (Bruch, 1970a). Eventually,
attempts were made to differentiate Simmond's Disease from psychological anorexia nervosa. The chief diagnostic indicator of Simmond's Disease is the almost complete destruction of the anterior lobe of the pituitary gland (Rowland, 1970). It was finally recognized that the disorder can be differentiated both biochemically and clinically. Thus, the psychological origin of anorexia nervosa was once again established and has persisted to the present.

The disproved theories of endocrinological imbalances in anorexia nervosa were soon replaced in the 1940's by psychoanalytical interpretations. The disorder was then viewed as the result of disturbing experiences in the patient's life which led to psychological conflicts (Bruch, 1970a). This school of thought has predominated for the past thirty years and has had profound impact on current clinical and medical approaches to anorexia.

An offshoot of the psychoanalytical approach, which has gained a reputation in the past decade, is that of family therapy. Its central theory emphasizes the impact that an individual's social system has upon him, specifically his immediate family (Minuchin, 1969). The anorexic's symptoms of food refusal are said to be supported by the dysfunctional
structure of the family (Aponte, 1973). The family inadvertently focuses on the patient's symptoms "as a way of avoiding or detouring . . . family conflicts (Leibman, Minuchin, & Baker, 1974, p. 434)."

The most recent approach to anorexia nervosa is that taken by proponents of learning theory (Bachrach, Erwin, & Mohr, 1966; Lang, 1966). The so-called neurotic behaviors of anorexics are viewed as "unwanted responses of the organism, elicited by a determinable class of stimuli (Lang, 1966, p. 217)." The individual is said to have acquired or learned unwanted behaviors, which must be replaced with more desirable behavioral responses. The approach is strictly a behavioral one, focused on restoring and maintaining eating behavior, with no attempts to assist the patient in gaining insight or discovering his unconscious motives (Lang, 1966). Consequently proponents of psychotherapy are highly critical of the use of behavior modification in the treatment of anorexia nervosa (Bruch, 1974), despite reports of its high success rates (Bacarach, 1965; Halmi, 1975; Stunkard, 1975).

The concept of anorexia nervosa continues to be the object of clinical controversy, due to the widely divergent psychological approaches which have developed in the past
century. The single point of agreement for most clinicians is the stereotyped symptomatology which presents itself in each case study. The current clinical picture of this disorder will not be more clearly defined until more extensive research is completed with long term studies of anorexic patients. Hopefully, such studies will be undertaken by the proponents of a wide variety of psychological approaches.
THE PRE-MORBID PERSONALITY & PRECIPITATING FACTORS

Much speculation has been made as to the possibility of a typical pre-morbid personality type in connection with anorexia nervosa. While some authors maintain that it occurs in any personality type (Goodsitt, 1969), current studies do indeed report findings of a number of common characteristics among anorexics. The majority of the patients are said to be highly intelligent and most successful in their educational endeavors (Ushakov, 1971; Rowland, 1970; Halmi, 1974; Kolb, 1966). They are set apart from their peers by intellectual achievements, but rarely by their personalities. Most clinicians describe these individuals as being quite shy and reserved, and often over-sensitive (Ushakov, 1971; Rowland, 1970; Kolb, 1973). They display unusually high principles for their ages, and strive for a life of perfection (Bruch, 1973; Galdston, 1974; Kolb, 1973). Parents of anorexic patients describe their children as being very compliant and obedient; model children who always conform to their parental wishes (Bruch, 1970a & 1973; Galdston, 1974; Goodsitt, 1969). Prior to the onset of
anorexia nervosa, obsessive-compulsive traits are frequently noted by the individual's family and friends (Halmi, 1974; Rowland, 1970; Seligmann, 1974). The patient appears to be obsessed with controlling every aspect of her life (Seligmann, 1974).

It is interesting to consider such observations in light of the typical family background which has come to be associated with this psychogenic disorder. The anorexic invariably comes from a highly prosperous family with above average living conditions (Ushakov, 1971). The father, like the anorexic child, is often quiet and reserved; a passive man who remains somewhat detached from the patient (Rowland, 1970; Szyrynski, 1973; Selvini, 1970). Conversely, the mother is said to be overcontrolling and possessive, dominating the child and entire family to an excessive degree (Rowland, 1970; Gifford, 1970; Selvini, 1970; Szyrynski, 1973). The family may outwardly appear to be a stable one. Yet, on closer inspection, it is often the case that the parents share a cold and loveless relationship (Groen & Feldman-Toledano, 1966). They are unable to demonstrate their feelings of affection for one another, and also, for their children (Groen & Feldman-Toledano, 1966).
Consideration of these family interactional patterns necessarily brings one to the investigation of possible precipitating factors. Although a wide variety of factors have been documented in the literature, those relating to the anorexic's familial relationships have recently gained the most attention. Current clinical interpretations of anorexia nervosa view the patient as a victim of family psychopathology (Aponte, 1973; Crisp, 1974). Due to the frequency of overcontrolling maternal relationships, Rowland (1970) has concluded that the mother is instrumental in contributing to the illness of anorexic patients. For example, dysfunctional family relations may be manifested in a hostile struggle for control between mother and daughter (Kolb, 1973; Gifford, 1970; Szyrynski, 1973). The girl, responding to an overcontrolling mother, disavows her own femininity in an attempt to deny any identification with her maternal model (Szyrynski, 1973). There is the possibility that the anorexic thereby gains a sense of personal control by self-starvation, which eventually leads to the disappearance of secondary sexual characteristics (Bruch, 1973).

The onset of puberty and accompanying fears of sexuality have frequently been credited as major precipitating events in
anorexia nervosa (Wall, 1959; Margolis & Jernberg, 1960; Rowland, 1970; Szyrynski, 1973). The young girl who has not been adequately prepared for physical changes may feel threatened by the presence of menarche and increased attention from the opposite sex (Wicklund, 1973). There is a possibility that "sexuality and eating become equated and associated with growing up and with oral impregnation fantasies (Wall, 1959, p. 998)." The patient may refuse food in an attempt to stalemate sexual development (Gardner, 1955). She is then pleased with the cessation of menstruation and her disappearing sexual characteristics (Kessler, 1966). Self-starvation becomes reinforcing, and temporarily affords her protection from having to cope with a new sexual identity.

There is little agreement among clinicians as to whether pre-morbid disorders of nutrition are causal agents in anorexia nervosa. Some studies report that the majority of anorexics have suffered from prior eating disorders (Ushakov, 1971; Crisp, 1970a; Kolb, 1973; Kessler, 1966). Many patients were previously obese or subject to compulsive eating. The factors of high birth weight and high growth rate are, according to Crisp (1970b), "significantly positively associated" with anorexics, (p. 23). Bruch (1973), on the other hand, main-
tains that only a small number of her patients were previously obese.

Regardless of pre-morbid weight, most authors do agree that the majority of anorexics have shown some prior pre-occupation with eating (Bruch, 1973; Kessler, 1966). Furthermore, food often has a special importance for the parents (Goodsitt, 1969; Kessler, 1966). When a girl comes from a household that is already diet conscious, it is easy for her to gradually decrease her food intake without gaining undue attention (Bruch, 1973). Such dieting may initially be undertaken for a variety of reasons. Some patients report that they begin with the sole intention of slimming down. When praised for their weight loss, they then decide to lose more weight (Bruch, 1973). Others are incensed by derogatory remarks about their figure (Rowland, 1970; Bruch, 1973), while some diet when confronted with new life experiences which cause separation from the family (Bruch, 1973; Aponte, 1973; Selvini, 1970).

It is obvious that the possible causal agents behind anorexia nervosa are both numerous and diverse. Clinicians appear to be in greater agreement on the existence of a typical pre-morbid personality and family background.
Although a large number of anorexic patients do appear to share common characteristics and backgrounds, there is a substantial number of individuals who do not. The existence of this percentage should signal clinicians to be highly objective and cautious in the compilation of their patients' case histories. There appears to be an inherent danger in dealing with anorexics, in that a clinician may make prior assumptions about the stereotypy of the patient's personality, background, and contributing motives. By prematurely labeling the situation, the therapist then enters the initial interview with certain suppositions about his patient which may be highly inaccurate. Furthermore, he may inadvertently conduct the interview in a leading manner, asking questions in such a way that the answers can only confirm his prior assumptions about the individual.

It would be difficult to determine how many anorexic case studies have been misconstrued by such factors of subjectivity and misinterpretation. As more reports confirm the existence of common personality traits, backgrounds, and precipitating factors, it may be a natural inclination for a clinician to evaluate his patient primarily in terms of such prototypes. A serious clinical mistake such as this can only
be avoided when objective interviewing techniques are employed, avoiding any prior assumptions about the patient falling into typical categories. Each patient must be evaluated on a strictly individual basis. This is a critical step in dealing with all anorexics; by this means alone can the most appropriate therapeutic approach be chosen. The clinician who assumes that all anorexic patients are psychodynamically alike, will undoubtedly encounter therapeutic roadblocks.
DIFFERENTIAL DIAGNOSIS

Anorexia nervosa has been reported in the past decade, as increasing in frequency (Rowland, 1970; Duddle, 1973; Selvini, 1970). Yet, there is the possibility that the disorder is simply being recognized more frequently. The literature on anorexia nervosa is characterized by a lack of differentiation between many types of physical emaciation. Fortunately, in the past few years, a number of clinicians have emphasized the need for differential diagnosis (Bruch, 1965; Tolstrup, 1975). First and foremost, it must be recognized that not all individuals who have undergone an extreme loss in weight, are necessarily suffering from anorexia nervosa. There are any number of unspecific psychological disorders involving weight loss, that may deceptively resemble anorexia, but which can ultimately be identified as atypical (Bruch, 1965).

A brief review of the outstanding clinical features of anorexia nervosa offers a starting point for any differential diagnosis. The anorexic patient is typically female, between the ages of ten and twenty, and has undergone a severe weight loss, due to her deliberate refusal of food. This results in
cachexia, accompanied by a lowered basal metabolism, reduced blood pressure and pulse rate, constipation, and amenorrhea (Tolstrup, 1975; Thomae, 1963; Bruch, 1965; Bruch, 1973). The latter may be one of the first symptoms to appear, or it may occur as emaciation becomes more pronounced (Thomae, 1963). No physiological causes such as tuberculosis or malignancy are present, the disorder is psychologically determined (Bruch, 1973).

Although anorexia nervosa and Simmond's Disease resemble one another in symptomatology, a differential diagnosis is, in fact, a simple task. Cachexia and amenorrhea are typical of both disorders, but emaciation is markedly more severe in anorexics (Ushakov, 1971; Szyrynski, 1973). There is no endocrinological disturbance in anorexia, as evidenced by the retention of pubic and axillary hair (Szyrynski, 1973; Williams, 1974). Laboratory tests can further differentiate the two disorders. The patient suffering from Simmond's Disease is usually characterized by apathy and dullness (Ushakov, 1971; Wall, 1959). In contrast, the anorexic remains highly active and restless, despite severe malnutrition (Bruch, 1973; Szyrynski, 1973; Margolis & Jernberg, 1971; Ushakov, 1971).
Other conditions involving psychologically determined weight loss, which are often confused with anorexia nervosa, can be differentiated in a number of ways. First of all, amenorrhea may be present in some of these cases, but not with the same regularity as in anorexia. These patients are highly concerned with their weight loss, which is usually related to some other psychological problem (Bruch, 1973). If they value their loss in weight at all, it is only for its potential in controlling other people (Bruch, 1973). They do not display a strong desire to remain thin. Furthermore, they are subject to fatigue and appear to be listless (Bruch, 1973).

The individual suffering from primary anorexia nervosa typically denies any concern about her emaciated state (Gifford, Murawski, & White, 1970; Thomae, 1963). Rather, she is eager to lose more weight and will resist any encouragement to eat (Bruch, 1973; Ushakov, 1971). Also, as previously mentioned, the anorexic continues to display an excessive drive for activity, which seems remarkable in light of advanced stages of emaciation (Szyrynski, 1973; Ushakov, 1971; Bruch, 1973).

Bruch (1965) has delineated three areas of "disordered psychological functions (p. 560)" which, she states, indicate the true syndrome of anorexia nervosa. The first area
involves a "disturbance of delusional proportions in the body image (p. 566)." Other authors have also noted the anorexic's persistent denial of their emaciation as being abnormal (Tolstrup, 1970; Thomae, 1963). The patient perceives her already thin body as overweight (Galdston, 1974; Gottheil, Backup & Cornelison, 1969; Bruch, 1965).

The second area of disturbance involves an inaccuracy in the "perception of stimuli arising in the body (p. 566)." The patient appears to be unable to recognized hunger. There is a persistent "absence or denial of desire for food (p. 566)." Some individuals who do give in to the impulse to eat, then gorge themselves. This momentary lack of control may then be followed by self-induced vomiting (Thomae, 1963).

The third characteristic disturbance is what Bruch (1965) calls a "paralyzing sense of ineffectiveness (p. 561)." The patient perceives herself as responding only to the demands of others, never acting on her own initiative. It has been noted that anorexic children are frequently described as highly compliant and obedient. Bruch (1965) concludes from her studies that these children have not learned to be independent and to rely on their own resources. When their lives eventually require more of them than "conforming obedience,"
they are unable to function in an autonomous manner. Considering the numerous reports of overcontrolling mothers of anorexics (Rowland, 1970; Kolb, 1973; Gifford et al., 1970), it seems quite likely that normal attempts by a child to become independent, would be strongly discouraged.

Whether or not these three areas of disturbance are indeed characteristic of primary anorexia nervosa, it is important to note Bruch's careful attempt at differential diagnosis. These delineations were made in an attempt to discriminate anorexia nervosa from numerous types of "psychologically determined emaciation (Bruch, 1970b)."

Much of the past confusion surrounding the classification of anorexia nervosa, has undoubtedly been due to a lack of proper differentiation. Food rejection is extremely common, and if one wishes to describe all forms as anorexia nervosa, then this disorder certainly does not exist as a separate clinical entity. Yet, as Ushakov (1971) points out, anorexia is a specific form of food refusal found in adolescents, which shows such "constant and well-defined stages of development, that it can only be safely assumed that it is a distinct clinical entity . . . (1971, p. 274)."

Assuming that anorexia nervosa is a separate clinical entity, some authors maintain that the disorder is easily
recognized (Tolstrup, 1975). The symptomatology is repeatedly described in similar terms, and the true syndrome appears to be quite uniform (Bruch, 1965). However, one cannot ignore the various factors which frequently impede an accurate diagnosis. As previously noted, the clinician must take care to differentiate anorexia nervosa from other psychological conditions involving weight loss. The primary form of the disorder appears to be characterized by a "relentless pursuit of thinness as the driving motivation . . . (Bruch, 1973)."

Additional obstacles in the diagnostic procedure are related to the anorexic's typical mental attitude. Many clinicians find that the anorexic patient is shy and guarded, and cannot be depended upon to be truthful (Selvini, 1970; Thomae, 1963; Bruch, 1973). Furthermore, they maintain a determined, if not stubborn campaign to emaciate themselves (Selvini, 1970). Ideally, the diagnostician should try to develop some sort of rapport with the patient, to better insure the validity of the patient's disclosures. Initial attempts at diagnosis may be met with resistance, making the procedure a long and tedious one. Yet, the clinician must be prepared to cope with such factors if an accurate diagnosis is to be made.

Although the actual number of anorexic patients who die is small, the ultimate possibility of death is present in all
cases (Donovan, 1975; Browing & Miller, 1968; Szyrynski, 1973; Bruch, 1971). This serious aspect of the disorder further indicates the need for an exact differential diagnosis. The therapist should have extensive knowledge of the disorder, as well as adequate experience with anorexic patients. Many diagnoses of anorexia that are reported in the literature, are made by individuals who have had limited exposure to true anorexics. Some patients are previously labeled anorexic in hospital records, and their current therapist then accepts such labels without a new evaluation. One can only question the validity of such practices. When it is not known who made the original diagnosis, or what their qualifications are, questions should be raised concerning the actual existence of the disorder.

Perhaps one of the most important reasons for completing an intensive and cautious diagnostic procedure, is its direct impact on the prognosis of the disorder. Therapeutic errors can best be prevented by completing a thorough investigation of the medical, psychological, and social factors contributing to each individual's case history.
THERAPEUTIC CONSIDERATIONS

Any therapist who plans to initiate treatment of an anorexic, should first be aware of some of the major factors which will affect his efforts, regardless of which psychological approach is chosen.

Anorexic patients are most often described as uncooperative, and highly resistant to treatment (Ushakov, 1971; Thomae, 1963). Furthermore, their persistent denial of illness and apparent enjoyment of weight loss are likely to be the source of frustration and anxiety for the attending therapist (Thomae, 1963). As a result, there is the natural danger that the clinician will respond to his patient with the same anger and anxiety that characterizes most parental reactions (Selvini, 1971; Browning & Miller, 1968). Just as the patient may have used his refusal of food to unconsciously manipulate his family, he may attempt to do the same with his therapist. The power struggle which may ensue can only interfere with therapeutic effectiveness (Browning & Miller, 1968). Goodsitt (1969) advises that the clinician never employ non-eating as "a bargaining point (p. 118)."

Another serious consideration in the treatment of anorexia
nervosa is the constant threat of death. However, Browning and Miller (1968) report that most anorexic patients are able to maintain extremely low levels of weight for prolonged periods of time. They conclude that this fact should afford a therapist some relief, allowing him to feel less coerced, and freer to deal with his patient effectively.

An initial decision to be made by the therapist, is whether or not the patient will be hospitalized. The literature reveals what appears to be a universal approach, that of separating the patient from his family, and placing him in a hospital or institution (Kolb, 1973; Wall, 1959; Galdston, 1974). It has been maintained that such a separation allows the individual to mature, and to become more independent, thereby diminishing the probability of symptom recurrence (Szyrynski, 1973; Galdston, 1974). However, some authors have voiced their misgivings about such practices, questioning its need and advisability. Rowland (1970) states that:

> It seems peculiar to take a patient's illness, treat it, and then to return the patient to the same constellation without any attempt to alter it. Anorexic patients do eventually return to their families and it would seem that some attempt to understand and treat the family is necessary (Rowland, 1970, p. 124).

A follow-up study by Browning (1968) of thirty-six female patients who had been hospitalized with anorexia nervosa,
concludes that "hospitalization should not be considered a prerequisite for successful outcome (p. 1128)." No statistically significant relationship was found between the two factors.

Perhaps the wisest approach in determining the need for hospitalization is that of making individual evaluations. Each patient's medical, psychological, and social situation should be examined in an effort to determine the efficacy of various therapeutic settings.

As previously noted, individuals suffering from anorexia nervosa are highly resistant to treatment. When an anorexic patient's weight has increased and appears to be stabilized, the therapist is relieved, and often interprets such a development as recovery. Yet, a note of caution should be sounded. This disorder has come to be known for its cycles of remissions and recurrences (Tolstrup, 1975; Rowland, 1970). Many patients whose physical and psychological difficulties appear to be resolved, later return for treatment in a matter of months (Bruch, 1971). Any diagnosis of recovery should be made with the greatest of care. The premature withdrawal of medical and psychological support could contribute to unforeseen relapses, and in some cases, the possibility of death.

The therapist who is about to undertake an anorexic case, should be aware of the clinical considerations noted
here. These factors will undoubtedly have a major impact on therapeutic success. By anticipating resistance, possible power struggles, and personal frustration, the clinician will be better prepared to handle a difficult patient.
CURRENT MODES OF TREATMENT

Current psychological approaches to anorexia nervosa are quite diverse. The treatment of this disorder has undergone extensive change throughout the past fifty years. Clinicians in the 1920's relied on the manipulation of the patient's diet to arrest the syndrome. Fresh calf's liver, beefsteak, and lamb kidney were suggested as appetite stimulants (Bartlett, 1928). Other practices included the administration of cod liver oil and iron (Hobhouse, 1925).

Since that time, therapeutic approaches to anorexia nervosa have been most highly influenced by psychotherapy. The literature reveals that the majority of anorexic patients are treated with some form of psychotherapy. Recently, however, behavior therapy has gained recognition for its reported efficiency in restoring eating behavior in the anorexic.

Further developments in the treatment of the syndrome have been stimulated by a new shift in attention to the contribution of family psychopathology to the anorexic's problems. Family therapy often utilizes methods from both psychotherapy and operant conditioning.

Each of these therapeutic approaches will be reviewed, with special emphasis on both their positive and negative
aspects. Anorexia nervosa is a serious disorder placing unusual demands on the therapist. Therefore, the selection of a particular form of therapy for each patient, should take into consideration not only the needs of the client, but also those of the clinician. Ideally, the therapist should choose an approach which he expects to be highly effective, but which he will also feel comfortable employing.
PSYCHOTHERAPY

The literature dealing with the use of psychotherapy in relation to anorexia nervosa is characterized by inconclusive findings. Many studies do not clarify the exact form of therapy used, or the type of anorexic patients involved. Seldom is a criterion described for recovery or improvement. Therefore, it is often impossible to make any correlation between technique and results. Reported success rates should be regarded with some degree of skepticism, as long term follow-ups are not always completed.

The literature describes the use of a wide variety of psychotherapeutic techniques in relation to anorexia nervosa. Most clinicians prefer to personalize their techniques, using some basic psychotherapeutic concepts, but also innovating new methods of their own. The majority of contemporary therapists stand in agreement that the use of traditional psychoanalysis is ineffective in the treatment of anorexia nervosa (Selvini, 1970; Galdston, 1974; Rowland, 1970, Bruch, 1973). However, a few clinicians still maintain that its influence on anorexic patients is more favorable than any other approach. Thomae (1963) reports that the use of
interpretative techniques can break down resistance, and ultimately facilitate personality change. He warns against the sole use of sympathetic understanding. Unless the patient is actively led to disclosing her problems through interpretation, she is likely to regress more deeply into sickness. By means of following psychoanalytical rules, eight of nineteen patients were supposedly improved or recovered. It is interesting to note that an additional nine patients were diagnosed as experiencing spontaneous recovery.

Szyrynjski (1973) reports that two thirds of his patient population showed improvement following the administration of dynamic psychotherapy. This approach involves ventilation, desensitization to food and eating, introjection of the therapist's attitude, and an adjustment of the patient's environment. The problems of food refusal are not directly dealt with in the first stages of therapy. Rather, an effort is made to strengthen the total personality for future change.

The patient is usually removed from his house and placed in a hospital, or with another family. Furthermore, it is considered wiser to alter the individual's attitude toward his parents, rather than attempting to overcome parental resistance.

Two underlying conflicts, sexual fears and hostility toward the mother, are dealt with in the process of ventilation.
The therapist and patient engage in open discussion, interpreting the individual's letters, diary, and dreams. The clinician attempts to dispel any inaccurate sexual ideas which the patient may have, such as a fear of oral impregnation.

Secondly, the mother is presented as "a more ordinary human being (Szyrynski, 1973, p. 501)," who has problems and weaknesses of her own. This stage of therapy is said to allow the patient a more realistic view of her current problems.

As the individual spends more time in therapy, she has the opportunity to observe the well-adjusted personality of her therapist. Both the verbal and non-verbal behavior of the clinician serve as an important model. The patient may now unconsciously incorporate some of the desirable qualities of her therapist, thereby strengthening her own weakened ego.

The last step in therapy is the desensitization of the patient toward food and eating. This is brought about by means of the therapist discussing those threatening topics in a calm and objective manner. Once again, the patient is said to observe the therapist's relaxed behavior, and then introjects comparable attitudes. The open and frank discussion of the individual's aversion to food, enables her to face her problem more easily. Additional desensitization procedures involve
conversations pertaining to nutrition and the counting of calories.

Traditional psychotherapeutic practices such as those just described, have proven to be not only useless, but damaging for some anorexic patients (Bruch, 1973). By confronting the patient with interpretations of her unconscious motives, the therapist may be repeating the pattern of interaction between parent and child. The anorexic is faced with additional evidence that she, herself, does not know her own feelings, thoughts, and intentions (Bruch, 1970b). This may result in increased resistance to therapy and to interpersonal contact (Selvini, 1971).

Bruch (1973) maintains that the clinician who relies on the traditional model "may be tempted to superimpose preconceived notions on the patient (p. 57)." Her personal approach to anorexia nervosa emphasizes the need for listening to the patient, and taking a temporarily less active role in the process of therapy. The individual is given the opportunity to freely express herself, without immediate interpretations and labels from her therapist.

Both Bruch (1970b) and Selvini (1971) report that the parents of anorexics have typically tried to force on their children, their own interpretations of the child's needs. Any
attempt by the child toward self-initiative and autonomy are firmly discouraged by the parents. This results in feelings of helplessness and ineffectiveness, as well as an inability to recognize one's own feelings and impulses (Bruch, 1973).

Bruch's personalized treatment approach centers around these developmental deficits. The main goal in therapy is "to make it possible for a patient to uncover her own abilities, her resources and inner capacities for thinking, judging and feeling (Bruch, 1973, p. 339)." It is considered essential that the patient become an active participant in therapy: when there are feelings and experiences to be uncovered, the patient is given the opportunity to make such discoveries on her own. As the therapist encourages self-awareness, the individual will hopefully become more confident in relying on her own impulses, thoughts, and emotions (Bruch, 1973).

Bruch (1973) has gradually developed this non-interpretative approach over a period of thirty years, following therapeutic difficulties and failures while treating anorexics with psychoanalysis. Her personal experience with anorexic patients indicates that as the individual learns to rely on her own resources, food refusal will become less and less of a problem.
Selvini (1971) also confirms the efficacy of such an approach, advising therapists to be sincere and unassuming with their patients. Clinicians are warned against reinforcing the patient's feelings of helplessness; offers of help and affection are to be avoided. The individual gains assistance in learning to rely on his own perceptions. Conjoint therapy sessions involving the mother and daughter, and male and female co-therapists are also used, and are reported to be highly effective.

Whereas some clinicians such as Bruch and Selvini delay any direct therapy concerning food refusal, others believe that the initial concentration should be on reinstating eating behavior (Tolstrup, 1975; Kolb, 1973; Galdston, 1974). The possibility of long term harmful effects due to a minimal diet should be kept in mind at all times. Tolstrup (1975) advises that each patient's physical condition be carefully evaluated prior to treatment, delaying psychotherapy until the individual has made a substantial gain in weight. He delineates three goals in treating the anorexic patient. The first is to "ensure survival (p. 77)," secondly to prevent any physical relapses, and lastly to remove "overt psychopathology (p. 77)." Tolstrup's studies indicate that the first two goals can be achieved for approximately one half to two thirds of any
patient population, but that the third goal is rarely achieved for more than a few individuals.

Galdston (1974) concludes from his study of fifty anorexic patients, that weight gain should take priority over the "acquisition of insight (p. 255)." His treatment technique is based on the concept that the anorexic refuses food due to a "phobia of bodily pleasure (p. 253)." Therapy is aimed at helping the patient regain personal control of such pleasure. The anorexic is informed by her therapist that she is evidently not able to maintain her own health, as evidenced by her extreme loss in weight. The hospital staff steps in and takes the responsibility of self-preservation from the patient, until she is able to display a certain degree of weight gain.

At each meal a staff member sits with the patient, occasionally feeding her, and frequently speaking of the necessity of feeding one's self. Privileges are granted only when weight is gained, while a further loss in weight results in restriction to bed and suspension of activities.

Psychotherapy is also included in the total therapeutic approach, with its form, intensity, and frequency varying from one individual to the next. These sessions are carried on in a non-threatening manner, consisting mainly of brief discussions. The therapist does not pressure the patient for disclosure of
his motives or feelings.

The criterion for discharge rests upon the patient's "demonstrated ability to enjoy herself . . . in interpersonal activity on the ward. This together with weight gain sufficient to keep the patient out of danger of malnutrition (Galdston, 1974, p. 256)," are a prerequisite for leaving the hospital. Galdston reports that out of all the patients meeting this criterion, none were ever in need of readmission for weight loss. Although the problem of food refusal was supposedly resolved in all but three cases, most patients continued to experience a fear of eating and getting fat, long after their discharge. It would appear that sustained weight gain was achieved by means of this therapeutic approach, but that the underlying personality problems accompanying the original weight loss, were still in existence.

Rowland (1970) reports equally negative findings in a long term follow-up study of thirty anorexic cases. Most patients upon discharge were considered to be fairly sick despite the recurrence of eating. The follow-up contacts revealed that few patients had undergone permanent personality change; original maladaptive personality traits were still evident. Most individuals were described as "evasive, manipulative, coercive, immature, and dependent (Rowland,
1970, p. 130)." These patients had undergone some form of psychotherapy, ranging from light discussions to insight therapy, for an average of ten months.

It is interesting to note that this study as well as many others (Ziegler & Sours, 1968; Bruch, 1971; Tolstrup, 1975) report a high incidence of symptom recurrence and continuing psychological problems. As Rowland (1970) describes anorexia nervosa, the "syndrome is one of remissions and exacerbations, and may require multiple hospitalizations (p. 130)."

A bleak picture such as this should raise some serious questions as to the correlation between psychotherapeutic approaches and expected prognosis.

The literature reports two separate studies which conclude that there is no significant relationship between the type of treatment used in association with anorexia nervosa, and the final outcome of the disorder (Seidenstecker & Tzagournis, 1968; Browning & Miller, 1968). Other factors such as age, educational achievement, degree of weight loss, and duration of symptoms were considered to be more important in determining the likelihood of recovery (Seidenstecker & Tzagournis, 1968). Yet, in direct contradiction, Browning (1968) found age, amount of weight loss and duration of symptoms to be unimportant with regard to final outcome.
Conflicting reports such as these characterize the confusion associated with the role of psychotherapy in treating anorexia nervosa. Many studies reveal incomplete descriptions of their treatment techniques, omission of criteria used in the diagnosis of recovery, and the absence of long-term follow-ups. Thus, true efficacy of such approaches cannot be easily determined.

Additional drawbacks that appear to be related to psychotherapy are the temporal and financial factors which are involved. Many anorexic patients are reported to remain in therapy for a year or more, spending most of that time hospitalized and separated from their families. Considering the rising costs of medical and psychiatric care, such extended periods of treatment can only become a financial burden for most patients.

Furthermore, the longer the patient is separated from her family, the more distant her problem becomes to them. Her eventual return to the home setting may constitute a crisis for the family who has become accustomed to not coping with her problems.

Another danger is that prolonged treatment may encourage the anorexic to develop a highly dependent relationship with her therapist.
In light of these considerations, it would appear that a highly effective therapeutic approach to anorexia nervosa would be one which facilitates the early return of the patient to her family and peer group. Friction associated with the readjustment to family living can probably best be avoided by including the patient's family in the treatment program.

Psychotherapeutic approaches often view the anorexic in isolation, not dealing with the impact that her immediate family has upon her. Many relapses and conflicts occurring a few months after discharge, may be related to this practice. By educating and preparing the family for their daughter's return, it is more likely that she will permanently maintain her weight gain and current psychological adjustment.
ATYPICAL PSYCHOTHERAPEUTIC TECHNIQUES

The few therapeutic techniques that have been used with anorexic patients are somewhat difficult to categorize. They have either been used in conjunction with psychotherapy (self-image experience), or, their methods (anaclitic therapy and educative therapy) resemble psychotherapy more closely than any other psychological approach.

Anaclitic therapy (from the Greek word anaklinein, meaning to lean upon) is a somewhat unusual approach which has been used on a limited basis with anorexic patients. Margolis and Jernberg (1960) report a case involving a forty-eight year old, married woman, whose anorexia was successfully treated by this procedure. Although this particular individual does not fit the conventional pattern of most anorexics, due to her age and marital status, she did display all of the stereotyped symptoms, with the exception of amenorrhea.

This disorder appeared to have been triggered by her husband's demands for fellatio. Despite continuing emaciation, she resisted psychotherapy sessions involving history taking and inquiries about her feelings. At this time, anaclitic therapy was undertaken.
The theoretical basis of anaclitic therapy, rests upon the notion that the creation of a dependency relationship between patient and therapist, will ultimately allow the patient to give up her resistance. She will no longer decline help, but accept it willingly after reliving the "infantile conflict (Margolis & Jernberg, 1960, p. 281)."

Treatment involves responding to the patient as if she were an infant or small child. She is attended to by the staff in a tending and loving manner. The patient's forehead is stroked, her hand held for hours at a time, and she is given warm baths and alcohol rubs. The therapist's encounters with the anorexic are characterized by "deliberate omniscient behavior (Margolis & Jernberg, 1960, p. 291)," continuing kindness and indulgence, all in an effort to strengthen the patient's confidence in him.

This period of treatment is referred to as the "catabolic process" whereby the patient's anxiety is alleviated, and she begins to trust her therapist. The latter phase, or "anabolic process" involves a change in perspective, as the anorexic begins to view the therapist as a desirable model, rather than a nurturing mother. She can now freely express her emotions without the fear of being rejected or punished. It is said that
during this final stage, the ego is strengthened, allowing the patient to become more independent.

The therapeutic procedure for this particular patient lasted thirteen and a half months. A follow-up report indicated that she was able to maintain her weight and good health, despite separation from her husband.

Since this approach has not been used extensively in the treatment of anorexia nervosa, it is difficult to make any legitimate conclusions about its effectiveness. The drawbacks in such a procedure are quite obvious. It places constant demands on both the therapist and hospital staff, requiring unlimited time and patience of them. Furthermore, serious questions should be raised as to the advisability of deliberately creating such a strong dependent relationship. It is quite possible that some anorexic patients would regress to an infantile or childish state as planned, but would then continue to cling indefinitely to both the therapist and staff. Many individuals might not wish to give up the safety of the catabolic process, and would never progress into the anabolic process.

Further studies may determine the various personality types with whom it would, and would not be advisable to use anaclitic therapy. Until that time, clinicians should employ
such techniques with extreme caution, in the treatment of anorexia nervosa.

The "educative treatment" of anorexia nervosa (Groen & Feldman-Toledano, 1966) is slightly similar to anaclitic therapy, in that a mothering approach is taken by a female therapist. However, a male therapist also interacts with the patient, and together the co-therapists temporarily act as loving parents for the anorexic.

The syndrome is viewed as the result of a lack of love from the natural parents. The anorexic is said to encounter some difficult situation in her life, which she is unable to handle without emotional support from her parents. Her emotional security is severely threatened, and she then regresses to a pattern of food refusal usually seen in much younger children.

Traditional psychoanalytical procedures are considered inappropriate, as the patient's emotional status appears to be that of a child. Groen & Feldman-Toledano's approach treats the anorexic as a small child, despite age, offering her affection and small gifts. During meals she is told stories and praised for any eating behavior that occurs, no matter how limited. Food is never forced on the child, neither is she chastised for her refusal of it.
The most interesting aspect of this approach, however, involves the inclusion of the parents in educative sessions. They are not blamed, or made to feel guilty for their inability to express love for their child. Rather, they are told that their daughter is suffering from a disorder of the hypothalamic appetite center. The parents are encouraged to demonstrate their affection in small ways, such as kissing the child, and paying her compliments. The co-therapists serve as models for the parents, as well as offering them support and the opportunity to discuss their own marital problems. Neither child nor parents are engaged in "deep psychiatric treatment (Groen & Feldman-Toledano, 1960, p. 680)." The emphasis is on behavior, specifically the affectionate behavior displayed toward the child. It is hoped that the parents will observe this modeling behavior, and permanently adopt it.

This approach was reportedly successful in dealing with seven individuals suffering from anorexia nervosa. All of the patients were able to gradually withdraw themselves from the special care received in the hospital. It is suggested that the patient does not go directly home, but first reside in a home with a strong maternal figure. Outpatient visits with the therapists are continued on a weekly basis. The final return to their own home is usually a period requiring patience and
understanding on the part of the parents. The child will no longer be as compliant and submissive as she was prior to hospitalization. The therapists visit the family in the home offering continued encouragement and support for the parents.

All seven patients were reported to be in good physical and mental health, in a follow-up check ranging from one to six years.

The recovery of all the patients, as well as the short duration of therapy (an average of three months) are impressive factors in this study. Likewise, the elimination of a power struggle over food is always a positive factor. However, one drawback to educative treatment is that it requires a special personality of both therapists. The two clinicians must be prepared to work together on a very close basis, cooperating in their mutual maternal and patriarchal roles. The number of patients who have been treated by educative techniques is, of course, quite small, and further studies utilizing this approach are needed to validate its effectiveness.

The unusual technique of "self-image confrontation" exposes the anorexic to sound motion pictures of herself (Gottheil et al., 1969). The procedure is designed to help the patient become more realistic about her body image. As previously noted, anorexic patients typically view their
emaciated figures as overweight (Bruch, 1973). Seeing one's self in the mirror, or reviewing past and present photographs have been reported as ineffective in changing a patient's inaccurate body image (Rowland, 1970).

This approach was used in combination with psychoanalysis, although handled by different psychiatrists, and at different institutions. Once a week, the patient undergoes a self-image experience session, and every other week a behavioral recording session is completed. The latter involves filming the patient as she answers a standard set of questions concerning what time she got up, what food she last ate, and how it tasted. Then, in self-image sessions she views those motion pictures, and answers another set of standardized questions. This set asks who the person was in the film, what the patient liked and disliked about the picture, and what changes she would like to make in it. Gradually, earlier films are altered with more recent ones. The psychiatrist makes an effort not to develop a therapeutic relationship with the patient, although he does respond to her in an accepting, positive manner.

Gottheil theorizes that upon viewing these films, the patient will have to do one of three things. She can either deny her screen image, change her self-image, or "become disorganized (Gottheil et al., 1969, p. 249)."
The initial results with a seventeen year old anorexic were characterized by continued denial of her thinness, as evidenced by her answers to the standardized questions. Gradually, the hostile denials diminished, and the patient became more objective, recognizing the positive and negative aspects of her image. She was eventually able to admit that her appearance was both sickly and undesirable.

The patient was exposed to a total of 54 confrontations, and hospitalized for approximately 16 months. Upon discharge, she was maintaining her body weight, and displayed a more realistic body image. A two year follow-up revealed that she was still in good health, and well adjusted. The authors conclude:

Although recovery could possibly have been the result of psychotherapy alone, the changes which took place slowly against a great deal of resistance appeared to be associated with the continued and repeated self-image confrontations (Gottheil et al., 1959, p. 249).

This approach to anorexia nervosa is certainly an atypical one, which appears to have potential in treating one aspect of the syndrome. The alteration of the patient's self-image may facilitate the recurrence of eating, as well as an increase in self-reliant behavior. It is possible that self-image confrontation sessions could be used effectively in conjunction with any number of psychological approaches to anorexia nervosa. Its
value when unaccompanied by any other therapy appears to be questionable, but certainly merits further investigation in the form of controlled studies.
BEHAVIOR THERAPY

One of the most controversial approaches to anorexia nervosa is that of behavior therapy. Despite its reported efficiency in the rapid restoration of eating behavior, few clinicians are in agreement on the advisability of utilizing its techniques. Reservations are held not only by the proponents of psychotherapy, but by the therapists, themselves, who have treated anorexics with behavior therapy (Blinder et al., 1970; Leitenberg et al., 1968; Halmi, 1975). Most clinicians recognize this approach as a relatively new one, which has not yet been validated by long term follow-up studies in anorexia nervosa (Bruch, 1974).

The behavioral techniques employed in the treatment of anorexia nervosa usually take the form of individualized reinforcement programs (Halmi, 1974; Bachrach et al., 1965; Stunkard, 1975; Blinder et al., 1970), or the use of systematic desensitization (Lang, 1965; Halisten, 1965). The latter "attempts to inhibit anxiety evoked by a graded series of imagined scenes with concurrent deep muscle relaxation (Leitenberg et al., 1968, p. 211)."

Hallsten (1965) piloted a study utilizing systematic desensitization to re-establish eating behavior in a 12 year old
anorexic. This particular patient exhibited two separate phobias which were interfering with her daily living: a fear of storms, and a fear of becoming obese. The author states that:

Associating the eating of fattening foods with a situation incompatible with fear or anxiety would weaken the anxiety association sufficiently (Hallsten, 1965, p. 39).

The anorexic is trained in relaxation techniques, and familiarized with the proposed plans for treatment. Her phobia of storms was dealt with first, since it was viewed as a likely success. A graded hierarchy of most threatening, to least threatening situations associated with storms was developed. Within a week, the patient was able to visualize the most threatening situations and remain relaxed. No change in eating habits or weight occurred following this phase of treatment.

The mastery of this hierarchy was then followed by one relevant to the girl's fear of becoming obese. Once again, the patient was told to relax as previously trained, and then taken through the visualization of behaviors associated with the eating of fattening food. For example, this series included the imagining of sitting at a table, eating fattening foods, and seeing herself in a mirror, showing signs of weight
gain. The patient was able to remain relaxed throughout the initial session.

Furthermore, she was able to eat her entire evening meal that day, and exhibited increased eating behavior at all subsequent meals. A total of 12 sessions were undertaken, and the staff reported a gradual, positive change in the girl's personality. Her weight increased from 57 pounds to slightly above 80 pounds upon discharge. No other form of therapy was administered, and no attempt was made to uncover psychological conflicts. A five month follow-up revealed that the individual was eating normally, and maintaining her weight.

Positive reinforcement procedures used in the treatment of anorexia nervosa are designed to differentially reinforce eating behavior. The assumption here is that as the individual's frequency of eating is increased, her anxiety will gradually be alleviated (Leitenberg et al., 1968).

A study by Leitenberg et al. (1968) examined the effects of reinforcement on weight gain, eating, and physical complaints in two separate subjects. A ten day baseline period was followed by a non-reinforcement period, during which the patient's physical complaints were ignored, and no pleasurable activities were allowed. Next, a reinforcement period involved verbal
praise for eating gradually increasing amounts of food. At this time, privileges were granted contingent on weight gain. No exact amount of expected weight gain was specified, rather the therapist was deliberately vague about how much of a gain would determine privileges. The patient counted and graphically recorded the number of mouthfuls she ate at each meal, as well as her daily weight. Any positive statements about eating were verbally reinforced by staff members.

This subject's physical complaints, which had persisted for two years, were completely extinguished. During the reinforcement phase, both her caloric intake and weight increased, and continued to rise throughout treatment and following discharge. A nine month follow-up revealed that the patient was continuing to gain weight, and was in good health.

A second subject's treatment procedure omitted the baseline period, and began with an immediate non-reinforcement period. An additional phase of extinction was included, during which weight gain was no longer verbally reinforced, and privileges were withheld.

This patient's weight gradually rose from 69 pounds to 95 pounds, during the reinforcement periods. The extinction phase did not result in decreased eating and weight gain as
expected. However, this was attributed to a number of possible causal factors, such as the phase being introduced too late in the procedure, and not being maintained for a long enough time. A four month follow-up confirmed the stabilization of the individual's weight.

Leitenberg et al. (1968) conclude that selective reinforcement of eating behavior is an effective approach to the treatment of anorexia nervosa, since neither of his subjects gained weight until this procedure was instituted. The author maintains that this study is especially important in that the increase of eating and caloric intake could not be attributed to the supportive environment of the hospital, or to the expectations for success by the therapist. Both of these factors were present prior to the introduction of reinforcement, and did not, at that time, lead to any increases.

Another study undertaken by Halmi et al. (1975) isolated the anorexic in her room, with visiting privileges, social activities, and increased physical activity contingent on weight gain. The patient was required to gain 1.1 pounds for every five day period, in order to make one phone call, receive mail, have one visitor for one hour, and to be out of her room for one hour each day. Weight loss was consequtated by continued isolation and tube feeding until the patient once again
attained her prior weight at the beginning of the last five day period. Only one of eight patients required tube feeding.

A behavior modification program was also instituted for each patient upon discharge. The same amount of weight gain was required for special activities at home. Any loss in weight was to result in hospitalization for tube feeding. None of the patients required the latter, and were reported to be maintaining their substantial weight gains.

Both Blinder (1970) and Stunkard (1971) completed studies whose results also determined that increased activity may be used as an effective reinforcer for weight gain. For example, one patient was required to gain a half pound per day, to be awarded an unrestricted six hour period outside the hospital each day. The subject showed immediate and sustained weight gain, averaging four pounds per week for her six weeks of hospitalization (Blinder, 1970).

Stunkard (1971) points out that there is a wide variety of reinforcers available to most therapists. Increased activity need not be the sole reinforcer utilized, as each patient is likely to have individual likes and dislikes. One seventeen year old anorexic complained of the sedative effects of the chlorpromazine (a drug used to control nausea and vomiting) that she was receiving. She was then allowed decreased
dosages proportional to the amount of weight gained per day. This patient gained an average six pounds a week under this personalized reinforcement program (Stunkard, 1971).

Bachrach et al. (1965) report a case involving a woman whose weight had dropped over a six year period from 120 to 47 pounds. He maintains that behavior therapy can play a critical role in preventing death in serious anorexic cases. Eating behavior can be rapidly restored when time is of the essence to a failing patient.

The patient was placed in isolation, in a barren room containing only a bed, chair, and nightstand. At each meal, a staff member verbally reinforced any movement associated with eating. The criterion for reinforcement was gradually changed, so that she was required to eat increasing amounts of food. If the patient ate no food, she was left in isolation until her next meal. The woman's weight slowly rose to a safer level, and she was then allowed to have visitors, and take walks, all contingent upon increasing weight gain. Upon discharge, the patient had gained a total of 38 pounds.

As previously mentioned, the use of behavior therapy in the treatment of anorexia nervosa is a highly controversial practice. Bachrach (1970) warns that "the power of the
Operant treatment method requires caution in its application (p. 1096)." Weight gain alone does not indicate recovery from the disorder. One of Blinder's (1970) patients, whose weight had been restored by behavioral techniques, committed suicide shortly thereafter.

Bruch (1974) also reports that death in anorexia nervosa is not uncommon in patients who have gained substantial amounts of weight, but suffer a relapse months later. She maintains that behavior modification is a somewhat "simplisitic approach (p. 1419)," which can be truly dangerous for some patients.

Three anorexic patients seen by Bruch had all been treated with behavior therapy, and had gained weight. However, they soon lost it following discharge from the hospital. All three girls were said to have experienced behavioral programs as "brutal coercion, by which they were reduced to utter helplessness (Bruch, 1974, p. 1421)."

Bruch (1974) concludes that weight gain can be beneficial only when it is part of a broader treatment program which resolves the underlying personality conflicts. She points out the danger of behavior modification procedures being implemented by non-professionals who have no true experience with this disorder. There is always the possibility that deterioration
may not be carefully monitored, resulting in grave physical danger for the patient.

Serious allegations such as these cannot be ignored by the clinician who is considering the use of behavior therapy in the treatment of an anorexic. However, total rejection of its techniques does not seem warranted. Its limitations should undoubtedly be recognized, and its further use adapted to such restrictions.

Major drawbacks appear to be related to behavior therapy's immediate but only temporary effects on eating behavior, its lack of long term follow-ups, and its adverse effects on certain personality types. It seems probable that the prolonged maintenance of eating may not be attained, due to the absence of additional therapeutic intervention. When treating anorexics, this approach will probably be most effective when used in conjunction with some form of individual or family therapy. Some clinicians may choose to initially increase the patient's weight by behavioral means. Then, as the individual's general health improves, some other form of therapy may be used to deal with underlying conflicts and personality problems.

Long term follow-ups should be routine in any study dealing with the treatment of anorexia nervosa. Most of the studies which have used behavior therapy, recheck on their
patients in four or five months. Ideally, this time period should be extended to a number of years at the minimum. The true efficacy of behavioral techniques in relation to anorexia, will not be determined until such rechecks are routinely practiced.

Clinicians should be aware that some anorexic patients may respond to operant conditioning techniques in an aversive, resistant manner. It would be foolish to assume that all anorexics can be effectively treated by any one psychological approach. Careful consideration of the patient's personality and background should contribute to the final selection of appropriate treatment techniques. Therapists can best prevent therapeutic roadblocks by maintaining a wide variety of techniques in their professional repertoire.
FAMILY THERAPY

Investigators of anorexia nervosa frequently describe the existence of family psychopathology, to which the patient inevitably returns, following hospitalization (Rowland, 1970; Bruch, 1973; Crisp, 1974). Despite the recognition that such pathology may contribute to symptom recurrence, few clinicians attempt any restructuring of the family system. Traditional approaches to anorexia direct therapy to the patient only, dealing with him in isolation from his family. The anorexic and his therapist can only talk about familial conflicts and pressures, there is no direct observation of their typical interactions (Landes & Winter, 1966).

Family therapy is a fairly new approach, whose use in the treatment of anorexia nervosa has gained much recognition. The patient's anorexia is viewed as serving a specific function in a dysfunctional family (Crisp, 1974).

By concentrating only on the symptoms of the patient, the parents were able to deny and avoid dealing with problems that existed between them or with the siblings. The symptoms were therefore reinforced within the context of the family (Leibman et al., 1974, p. 435).

Subsequently, the reconditioning of eating behavior, and signs of substantial weight gain, are not considered sufficient
for recovery (Leibman et al., 1974). It is likely that when
the individual returns to daily living with her family, a relapse
will occur.

This therapeutic approach maintains that the structure of
the family must be constructively changed, to free the patient
from her symptoms. The focus of attention is shifted from the
anorexic to the typical patterns of familial interaction which
are causing conflicts (Leibman et al., 1974; Barcai, 1971).
Most often, the patient is hospitalized, and therapy is begun
with the entire family. This temporary separation removes
the source of much anxiety and hostility from the home,
relieving the parents, and enabling the patient to become more
autonomous in her eating behavior (Berlin, 1953). Plans are
made to gradually reintroduce the child into the home situation,
once her weight has begun to increase (Landes & Winter, 1966).

Aponte (1973) initiates treatment by gathering the family
together for lunch sessions. After becoming familiar with
their transactional patterns and specific problem areas, the
therapist "sets the stage for disagreement (p. 10)." In this
way interactional conflicts are revealed, and the centrality of
the patient's illness is decreased (Barcai, 1971).

Such practices are often referred to as "crisis-induced
family therapy." Minuchin (1971) assigns the family a task
which will create a conflict that cannot be easily avoided. Many anorexic families are described as rigid and incapable of resolving problems (Leibman et al., 1975), they will typically detour conflicts (Minuchin, 1971). By introducing an unavoidable state of crisis, the family will find it necessary to respond in an atypical manner, which is likely to result in confusion and disagreement. The therapist can then redefine the actual family problems, designating specific areas of their malfunctioning. Likewise, the family is directed in the constructive resolution of the crisis situation. Grinker (1968) points out that using deliberate intervention techniques makes it essential for the clinician to be available at all times to regulate and support the unstable system he has created.

Despite the unusual demands this approach places on the therapist, many clinicians feel that its potential is unlimited (Donovan, 1975; Minuchin et al., 1969). The exact influence of family members on a patient is no longer a guessing game for the therapist. They are all present, revealing their dynamic patterns of interaction.

Recent consideration has been given to increasing the effectiveness of family therapy, by using it in conjunction with operant conditioning techniques (Leibman et al., 1974 & 1975).
A treatment program utilized by Leibman et al. (1974) involves the family of the anorexic soon after her admission, and during outpatient care as well.

Initially, the therapist holds informal lunch sessions with the patient, speaking of his physical responses to hunger, and offering to share his meal. In this way a power struggle over food and eating is said to be avoided. The proposed operant reinforcement program is explained to the patient, and she is informed that her family has no control over it. Furthermore, they are asked not to discuss it with the patient. These steps are taken "to give the patient an increased sense of autonomy and responsibility for her physical state (Leibman et al., 1974, p. 434)."

As in many behavioral programs for anorexia, access to physical activity is made contingent upon weight gain. A daily gain of half a pound or more entitles the patient to television, having visitors, the use of the bathroom, and four to six hours of unrestricted activity on the ward. When less than one half of a pound is gained, the individual is restricted to bed.

Family therapy lunch sessions are begun with two goals in mind. The therapist hopes to relabel the family problem, diverting the focus of attention away from the patient and her symptoms. Secondly, he wishes to neutralize eating, so that
the individual will be able to eat in the presence of her family without an ensuing power struggle. At this time a goal is also established for a final discharge weight. Leibman et al. (1974) report that all of their patients remained in the hospital for an average of one to two weeks following the first lunch session.

The outpatient phase of treatment revolves around three goals. The first is to eliminate food refusal and its symptoms so that the family can no longer avoid its problems by focusing on the anorexia. Secondly, the clinician attempts to illuminate the family patterns of interaction which encourage or reinforce the symptoms. Lastly, permanent change in the family functioning is sought to prevent future relapses.

An outpatient reinforcement program, to be enforced by the parents, is instituted. This is to maintain the patient's weight gain, and to provide "... the parents with something concrete to do at home, which decreases their anxiety and previous feelings of helplessness in dealing with their sick child (Leibman et al., 1974, p. 434)." Under this program the patient is required to gain a minimum of two pounds weekly to maintain normal activities on the weekends. If the patient does not gain, she is restricted to the house, and a family member must remain at home with her. The latter condition
brings the family together in a united effort to encourage the patient's eating.

The patient continues to gain weight, and the family's concern is shifted to the interpersonal conflicts being dealt with in the therapy sessions. The individual gradually loses her role as the family scapegoat, and can become reinvolved in school and community activities.

This particular combination of behavior and family therapy appears to foster few of the negative aspects so characteristic of other approaches to anorexia nervosa. Rapid and immediate weight gain is achieved, but more important, relapses are prevented by continuing intervention in an outpatient phase of treatment. Both the patient and her family are assisted in dealing with the anorexia in a more constructive manner, and are made aware of their dysfunctional patterns of interaction which have supported the anorexic symptoms.

Patients spend an average of fourteen days in the hospital, and an additional average of seven months in family therapy. The time factor is not excessive, thereby reducing the financial costs for the family. Furthermore, the individual is returned to her family and peer group in a relatively short amount of
time, preventing the establishment of a strong dependency relationship with the therapist.

 Obviously, there will be some anorexic patients whose illness does not appear to be supported by a dysfunctional family structure. This approach may not be a panacea for every individual suffering from anorexia nervosa. What is important is that a therapeutic approach has been devised, that warrants against the usual clinical roadblocks and unforeseen relapses so characteristic of the syndrome. Since most anorexic patients are adolescents, it is assumed that the majority of them return to their families following hospitalization. Therefore, it is quite likely that their immediate family has a maximal effect on their daily lives. The inclusion of family members in the entire treatment program will help to disclose the actual patterns of familial interaction, and determine their influence, if any, on the patient's anorexic symptoms. Even if causal agents are identified as originating outside of the family structure, family members can be assisted by the therapist in providing support and encouragement for the patient.

 One possible limitation to this procedure, which is not mentioned by its proponents, is therapeutic difficulty due to the limited cooperation of the family. It would seem that resistance on the part of any one family member could seriously jeopardize
the efficacy of this approach. Possibly, such resistance is not uncommon, but eventually dissipates during repeated and intense family sessions. Further reports, dealing with possible complications involved in this conjoint therapeutic approach, would be a valuable resource for the clinician who wishes to implement a comparable program.
SUMMARY

Anorexia nervosa remains a highly puzzling disorder for contemporary clinicians, despite the current increase in associated research. The relevant literature is characterized by confusion concerning the syndrome's classification, cause, and treatment. Much of this confusion appears to be due to a lack of proper differentiation between psychologically determined forms of emaciation. Furthermore, many authors report their findings in vague and incomplete descriptions, which complicate, rather than clarify the general picture of anorexia.

A wide variety of psychological approaches have been used in the treatment of anorexia nervosa. However, no single therapeutic modality has yet proven itself to be the most effective. What seems unfortunate is that the proponents of some approaches maintain that all anorexic patients can, and should be treated by any one method alone. This rigid adherence to the notion that all anorexics are psychodynamically alike, may be preventing valuable progress in experimental studies, wherein conjunctive forms of therapy could be tested for their effectiveness.
The clinician who wishes to institute a treatment program for individuals suffering from anorexia nervosa will probably encounter fewer complications by maintaining a diversity of techniques in his professional repertoire. In this way, he will be able to evaluate and treat each patient with the form of therapy which is most ideal for that person.

Traditional practices of excluding the family of the anorexic from any phase of therapy, should be reviewed at this time. The high incidence of symptom recurrence and relapse following a return to the family, may be an indication that they directly contribute to the patient's illness. The structure of the family and its typical patterns of interaction should be investigated for their possible influence on the existence of the disorder.

The prevention of anorexia nervosa is not, at this time, a feasible consideration. Preventive measures will not be available until the exact nature of the disorder is more clearly defined. The present emphasis should be on the early detection and treatment of the illness.

It is hoped that anorexia nervosa will continue to be the object of extensive research in the medical, psychological, and sociological fields. Future investigations will be critical in
developing effective therapeutic techniques for those individuals suffering from this unusual disorder.
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