EARLY ONSET ANOREXIA NERVOSA

by

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ABSTRACT

Two consecutive referrals of early onset (symptom onset at 11 years) anorexia nervosa (restricting sub-type) to an inpatient eating disorders unit in a psychiatric hospital, will be described. Within both cases, there was a history of sequential mother-daughter dieting prior to the daughter's onset of anorexic symptoms. This pattern will be viewed from the perspective of systemic theory, with reference to the cybernetic processes implicated in the onset and maintenance of symptoms. Structural systemic interpretations, in terms of exchangeable senses of self within the mother-daughter pairs, will also be considered. A brief comment will be made about the symmetry which underlies the choreography of anorexia nervosa when viewed from the perspective of communication theory. The implications for intervention will be addressed. In conclusion, the nature of the inter-generational transmission of disordered eating behaviours, will be considered with reference to the nature-nurture debate.

KEY TERMS: Early onset anorexia nervosa; Symmetrical relationships; Inter-generational eating disturbances; Premenarcheal anorexia nervosa; Family systems; Communication theory

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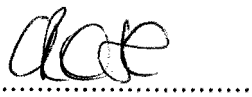
I declare that **EARLY ONSET ANOREXIA NERVOSA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



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CHAPTER 1

INTRODUCTION

> "From the vantage point of the historian, anorexia appears to be a secular addiction to a new kind of perfectionism, one that links personal salvation to an external body configuration" (Brumberg, 1988, p. 7).

Self-starvation has existed for centuries (Brumberg, 1988). Sours (1980) states that one of the earliest cases on record, is that of a third century buddhist monk who embarked upon a fast in order to seek enlightenment. During the middle ages, self-starvation manifested in witchcraft and pseudomysticism (Sours, 1980). Brumberg (1988) states that fasting was associated with holiness/spirituality in medieval Europe, particularly, for female saints (Brumberg, 1988). Saint Catherine is alleged to have eaten mainly herbs and forced twigs down her throat, to bring up her food (Brumberg, 1988). Brumberg argues that across time, social systems have sanctioned the control of women's appetites. However, the meaning of fasting has changed over time from that of "sainthood" to "patienthood" (Brumberg, 1988, p. 60).

Anorexia nervosa was first described in the medical literature in 1694, following which Gull, in 1868, and Lasegue, in 1873, reported cases of anorexia nervosa (Sours, 1980). In 1894, Collins reported a case of anorexia nervosa in a seven and a half year old girl (Collins, 1894). At the beginning of this century, Janet described a few cases (Sours, 1980). According to Sours during the early part of this century, anorexia nervosa was regarded as a pituitary disorder. However, the popularity of psychoanalytic theories during the 1930's led to a re-conceptualisation of the illness as a psychological disorder (Sours, 1980). Garfinkel and Garner (1984) state that over the past 100 years, anorexia nervosa has been considered to be a variant of a number of psychiatric illnesses, such as depression, schizophrenia, hysteria and obsessive-compulsive disorder. Early debates regarding the essential psychopathology of the illness are

aptly illustrated in the classic case of Ellen West (cited in Chessick, 1989); various diagnoses, including schizophrenia, were proposed by Binswanger and Kraepelin, who were involved with the case (Chessick, 1989). Since that time, controversy has existed (and continues to exist) regarding the exact aetiological processes and psychopathology of the illness (Bryant-Waugh & Lask, 1995). One of the most contentious debates is whether rates of anorexia nervosa have increased during this century, specifically, over the last few decades. Psycho-historians argue that the symptoms of anorexia nervosa were common in nineteenth century girls, however, these symptoms were diagnosed as chlorosis (the "green sickness") (Theriot, 1988).

Contemporarily, anorexia nervosa is regarded as a psychiatric disorder, characterised in essence by a drive for thinness and a refusal to maintain a minimally normal body weight, together with specific associated behaviours aimed at controlling body weight (e.g., food restriction; purging) (American Psychiatric Association, APA, 1993). Other presenting features include body-image distortions and unreasonable fears of fatness (APA, 1993). A complex web of inter-connected factors at the individual psychodynamic level; the physical level; the family systems level and the social systems level, appear to be implicated in the development of the illness. Various of these factors will be examined in the literature review of this report.

The literature review commences with a presentation of general diagnostic and demographic features. An overview of features specific to childhood onset anorexia nervosa is also provided. Physical factors (i.e., biological theories) implicated in the illness will be discussed, after which individual psychological factors will be reviewed with reference to psychodynamic theory; personality and cognitive features; as well as developmental factors. Family patterns which have been implicated in the onset and maintenance of anorexia nervosa will also be considered, as will family psychiatric illness and family eating disorders. The latter will be discussed with reference to genetic epidemiological studies, which raise the debate as to whether nature or nurture are implicated in psychological disorders.

The literature review is followed by a presentation of two case studies of anorexia nervosa. The purpose thereof is to illustrate the tendency towards symmetry in the illness. The latter perspective (based on communication theory) has not received a great deal of attention within the literature. The perspective of communication theory will be extended to include an analysis of the choreography of anorexia nervosa. The case studies will be used for illustrative purposes. Methodological and ethical issues pertaining to the use of case studies will be discussed with reference to the cases. The latter discussion will, however, follow rather than precede the case presentations. Although this is not the standard method of presenting such issues, to have presented the methodological and ethical issues first in isolation from the case material, would have de-contextualised the issues.

In terms of the case material, two consecutive referrals of early onset anorexia nervosa (restricting sub-type) to an inpatient eating disorders unit in a psychiatric hospital, will be presented. Both girls presented with histories of sequential mother-daughter dieting prior to the daughter's onset of anorexic symptoms. This pattern will be viewed from the perspective of systemic theory with reference to the cybernetic processes implicated in the onset and maintenance of symptoms. Structural systemic interpretations, in terms of exchangeable senses of self within the mother-daughter pairs, will also be considered, as will alternative psychological interpretations. The case material is presented in narrative form in order to protect the identity of the patients. The narrative follows directly after the literature review. In conclusion to the report, a brief comment will be made about the symmetry apparent in the cases, as well as the inter-generational transmission of disordered eating behaviours, with reference to the nature-nurture debate.

CHAPTER 2

LITERATURE REVIEW

> ...she looked like a walking skeleton...with her legs sticking out like broomsticks, every rib showing and her shoulder blades standing up like little wings...most striking was the face - hollow - like that of a shrivelled-up old woman with a wasting disease...(Bruch, 1978, p. 2)

The literature review commences with a description of anorexia nervosa, as delineated in the DSM-IV (APA, 1994). A description (and definition of) early onset anorexia nervosa is also provided. These descriptions portray what is meant in the literature review by the words "anorexia nervosa" and "early onset anorexia nervosa", both of which have acquired different meanings in different contexts. Staying within the ambit of systemic theory, which focuses on patterns and connections both within and between (sub) systems, various systemic factors implicated in anorexia nervosa, are discussed. The individual system, at a physical and psychological level is considered first, followed by a review of the family system, after which the social system, in which individuals and families are embedded, is discussed with reference to anorexia nervosa.

Diagnostic and Demographic Features

Diagnostic Features

The DSM-IV (APA, 1994) provides three diagnostic categories for the classification of severe disturbances in eating behaviour. The categories are as follows: Anorexia Nervosa (AN); Bulimia Nervosa (BN); and Eating Disorder Not Otherwise Specified (ED NOS). The latter category describes disorders which do not meet the full criteria for AN or BN (APA,

1994). The focus of this discussion will be on anorexia nervosa although it should be noted, that both anorexic and bulimic features may be evidenced by the same individual (APA, 1994).

Common presenting features in anorexia nervosa include: a disturbance in the perception of body shape and weight; an unreasonable fear of being fat or gaining weight; extensive efforts to control weight; and a denial that weight or eating habits are a problem (APA, 1994, p. 539). Weight loss is attained through a reduction in total food intake; exclusion of "bad" foods (e.g., high calorie foods); and purging (vomiting, laxatives) (APA, 1994; Kaplan & Sadock, 1989). Intense exercise regimens (running, walking, cycling, aerobics) are additionally commonly used as a means of losing weight. Persons with anorexia may be reluctant to sit down, due to anxiety that inactivity will lead to weight gain (Kaplan & Sadock, 1989).

The DSM-IV diagnostic criteria specify that the person's weight must be more than 15% below "normal", as determined by population norms for weight, height and age. She or he must display an intense fear of gaining weight or becoming fat; as well as display a distorted experience of body weight and shape (APA, 1994). The latter distortions are usually expressed as feelings of being globally overweight, as well as concerns that certain body parts are fat (abdomen, buttocks, thighs) even though this is objectively not so (APA, 1994). The "reality" of the subjectively reported disturbed bodily perceptions has been questioned and it has been proposed (Dare, 1993) that the apparent body distortion may be an attempt by patients to interpret/explain their aversion to eating.

Persons with anorexia nervosa commonly estimate their body size or weight through excessive weighing, obsessive measuring and/or using mirrors to check for perceived areas of fat (APA, 1994). Persons with AN are highly dependent on their body shape and weight for self-esteem - weight loss is considered an impressive achievement indicative of exceptional self-discipline and weight gain is considered failed self-control (APA, 1994). Denial of the seriousness of the emaciation is common (APA, 1994). Casper (1986b) describes the attitude as one of "la belle indifference" in relation to the signs of starvation although some persons may acknowledge being thin (APA, 1994). The DSM-IV specifies that amenorrhea must be

present in order for the diagnosis to be made. Finally, two sub-types are distinguished: (1) *restricting sub-type* in which weight loss is achieved mainly through dieting, fasting or exercising; and (2) *binge eating/purging sub-type* in which regular binging and purging is present, and in which the person may purge after eating even a small amount of food (APA, 1994). The latter sub-type of AN is distinguished from BN by virtue of the fact that persons with BN maintain their body weight at or above a minimally normal level.

Associated features in anorexia nervosa include depressive symptoms which appear to be secondary to starvation, as well as obsessive-compulsive features which may be related and unrelated to food (APA, 1994). Other syndromes accompanied by significant weight loss, such as major depression, are distinguished from AN by virtue of the fact that weight loss is not accompanied by a desire for weight loss or a fear of gaining weight (APA, 1994). Similarly in schizophrenic syndromes, there may be an aversion to food and a refusal to eat, however, this may stem from beliefs/delusions that food has been poisoned, rather than a desire for weight loss or a fear of gaining weight (Kaplan & Sadock, 1989; Selvini-Palazzoli, 1985b).

In terms of help-seeking, factors which may motivate a person to seek treatment include distress associated with binge eating and/or extreme weight control measures (e.g., self-induced vomiting, excessive use of diet pills and laxative abuse) (APA, 1994). Treatment motivation may also stem from impaired functioning associated with the eating disorder but it is unusual for persons with AN to complain of weight loss (APA, 1994). Lack of insight is common (APA, 1994). Families may request help due to the patient's loss of weight, food refusal, vomiting or amenorrhea (APA, 1994). Kaplan and Sadock (1989) state that anorexia, in its advanced stages, becomes extremely entrenched; patients are not receptive to reasoning, including the possibility that death may occur. The question has been raised as to whether anorexics are trying to kill themselves. According to Farrell (1995) various early clinicians (e.g., Charcot in 1889; Janet in 1929; Lorand in 1943) believed that this was so.

DSM-IV Diagnostic Criteria

The following diagnostic criteria, as stipulated in the DSM-IV (APA, 1994, p. 544) must be met for the diagnosis of anorexia nervosa to be made:

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, that is, the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., oestrogen, administration).

Specify Type:

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics or enemas).

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Demographic Features

Various factors, such as age, socio-economic status, gender and culture appear to be associated with anorexia nervosa. AN was until recently considered to occur mainly in high income groups but this trend appears to be changing (APA, 1993; Bryant-Waugh & Lask, 1995). Similarly, AN was previously considered a "white female" disorder, however, recent reports have documented the disorder in other ethnic groupings (APA, 1993; Szabo,

Berk, Tlou, & Allwood, 1995). More than 90% of AN cases occur in females (APA, 1994). The incidence appears higher in industrialised nations but few cross-cultural studies have been conducted (APA, 1994). Gender and cultural factors will be discussed in more detail in the socio-cultural section of this review.

In terms of age, adolescent females aged 14 to 25 years, appear most at risk, and onset is most common between the ages of 14 and 18 (APA, 1993, 1994; Bryant-Waugh & Lask, 1995; Nielsen, 1990; Stierlin & Weber, 1989). The mean age at onset is 17, with bimodal peaks at ages 14 and 18 (APA, 1994; Crisp, Hsu, Harding, & Hartshorn, 1980). The onset of anorexia nervosa is rare before puberty and after the age of 40 (APA, 1994; Kaplan & Sadock, 1989; Steinhausen, Rauss-Mason, & Seidel, 1991).

Incidence and Prevalence

Anorexia nervosa is estimated to occur in about 0.5% to 1.0% of the late adolescent and early adulthood female population (APA, 1994). Clinical cases of AN are rare in the population; subthreshold cases (i.e., Eating Disorder Not Otherwise Specified) are more commonly found (APA, 1994). Various authors (APA, 1993, 1994; Halmi, 1995; Kaplan & Sadock, 1989) claim that the rates of AN appear to have increased over the last 20 to 30 years. Eagles, Johnson, Hunter, Lobban, and Millar (1995) state that about half of the studies conducted from 1980 have found an increase, but the other half have not. Nielsen's (1990) study of psychiatric admissions from 1973 to 1987 in Denmark, found that neither the incidence nor the prevalence in male or female *new* cases had increased. However, a rising readmission rate was found. Nielsen states that the latter may have contributed to clinicians overestimating the incidence and thus assuming increased incidence. Eagles et al. (1995) found that rates of referral for treatment of AN in Scotland over a 27-year period had increased; however, patients presenting for treatment in 1970 to 1972 weighed less than those presenting in 1989 to 1991, suggesting that less severe cases were being referred (possibly due to greater public awareness). Bryant-Waugh and Lask (1995) state that greater recognition and increased reporting may explain the apparent increase in rates of anorexia nervosa. Community based population studies (Lucas, Beard, O'Fallon, &

Kurland, 1991) suggest a pattern of fluctuating rates across time (1935-1984). Lucas et al. in their 50-year study found that the incidence appeared to have increased in the 15 to 24 year old female population, but not in females in other age groups, nor in males.

Differences in methodology and research design may have impacted on the inconsistent findings regarding increased incidence. Studies reporting increased referrals are not comparable to studies based on psychiatric in-patient admissions. Similarly, studies based on retrospective medical records in community population groups are not comparable to student population groups or hospital groups. Retrospective studies based on medical records pose difficulties of their own and longitudinal prospective studies are needed. In addition, other factors which need to be considered in interpreting the epidemiological studies include changes in diagnostic criteria across time, as well as greater awareness, both of which may impact on diagnostic decisions.

Course, Prognosis and Outcome

Precipitating factors associated with the onset of symptoms include: puberty; menarche; attempted avoidance of growing up; first boyfriends and sexual experiences; separation from peers and/or home; changes in environment; significant parental conflict and/or divorce; family tension; family illness and/or death; and being teased about being overweight (Crisp et al., 1980; Mynors-Wallis, 1989; Stierlin & Weber, 1989). The course and outcome of the illness is extremely variable and ranges from full recovery (after one episode) to fluctuating patterns of weight gain followed by relapse (APA, 1994). Some patients may evidence a chronic deterioration over a number of years (APA, 1994). In patients whose weight is restored, other symptoms, such as ritualistic eating, depressive symptoms, and concerns about body shape/weight may persist (Crisp et al., 1980; Kaplan & Sadock, 1989). Steinhausen et al. (1991) in a review of 68 outcome studies (1953-1989) found that about half of all patients had a good (or very good outcome); 30% had an intermediate outcome and 20% evidenced chronicity. The time interval between treatment and follow-up appears to impact on findings, with more positive results being reported in longer interval studies (Dare et al., 1995; Stierlin & Weber, 1989). In a follow-up study of

102 patients, four to eight years after presentation for treatment, Crisp et al. (1980) found that close to 80% had normal (or near normal) body weight. These authors (Crisp et al., 1980) found an overall length of illness (in those who had recovered) of four years and a mean duration of illness of three years. Readmission occurred in about 20% of cases (Crisp et al., 1980). Methodological problems which have impacted on outcome studies include inadequate diagnostic criteria and descriptions of treatment; inadequate follow-up periods; and poorly defined outcome criteria (Gilchrist, McFarlane, McFarlane, & Kalucy, 1986; Hsu, 1983; Stierlin & Weber, 1989).

In terms of prognosis, factors associated with a good outcome include: early onset; short onset between symptoms and treatment; and good parent-child relationships (Becker, Korner, & Stoffler, 1981; Dare et al., 1995; Steinhausen et al., 1991; Stierlin & Weber, 1989). Mortality rates vary from 5 to 18% depending on the studies; long-term mortality appears to be over 10% and to result, inter alia, from starvation, electrolyte imbalances or suicide (APA, 1994; Crisp et al., 1980; Kaplan & Sadock, 1989; Steinhausen et al., 1991). Becker et al. (1981) found in their outcome study that those who had died at follow-up had neither evidenced insight nor motivation during treatment; had later onset (mean - 20 years); and greater average weight loss, as well as greater chronification (duration between symptom onset and treatment).

Childhood Onset Anorexia Nervosa

Childhood onset anorexia nervosa is believed to be rare, however, there are numerous reports of self-starvation in latency aged and preadolescent children (Alessi, Krahn, Brehm, & Wittekindt, 1989; APA, 1994; Collins, 1894; DiNicola, Roberts & Oke, 1989; Fosson, Knibbs, Bryant-Waugh, & Lask, 1987; Fundudis, 1986; Gowers, Crisp, Joughin, & Bhat, 1991; Hall, 1987; Irwin, 1984; Mouren-Simeoni, Fontanon, Bouvard, & Dugas, 1993; Norris, 1979). In 1894, Collins (1894, p. 202) reported a case of anorexia nervosa in a seven and a half year old girl. He described the mental "phenomenon" as "remarkable" and stated that the girl "persistently refused food...her emaciation was extreme...[she was]

intensely selfish...self-absorbed, very vain...pious in conversation...told long stories...concealed food in the bed...[and] expressed herself as not wishing to improve".

About 5% of anorexia nervosa cases are believed to occur in children below the age of 12 (Alessi et al., 1989). However, some studies (Irwin, 1984) report higher rates. Irwin's study found that 28% of patients were under the age of 13 and 7% under the age of 10. Locally, a South African study (Norris, 1979) reported that only one 10-year old girl was referred to a specialist eating disorder unit, in a three year period; the unit was, however, based in an adult psychiatric hospital. Bryant-Waugh (1993a) says that few studies of the incidence and prevalence in children have been conducted. It is thus not known exactly how many such cases occur, however, there are fewer cases of anorexia in the 8 to 13 year old group than in the 14 to 19 year old group (Bryant-Waugh, 1993a). Different gender ratios within childhood anorexia nervosa have been reported, in comparison to those reported in adolescence and adulthood. Higgs, Goodyer, and Birch (1989) found that 30% of their cases of childhood anorexia nervosa were boys, suggesting that a larger number of boys may present with anorexia nervosa in childhood, than in adulthood.

Diagnostically, weight loss in children may be less frequent than failure to make weight gains (Alessi et al., 1989; Irwin, 1981). Anorexia nervosa, also needs to be distinguished from food refusal or fussiness in young children even if certain features (e.g., refusal of food) are shared (Bryant-Waugh & Kaminski, 1993). Starvation (irrespective of the cause) in children, leads to an arrest in growth (Russell, 1985). Controversy exists as to whether the characteristics of childhood onset anorexia nervosa are the same as those of adolescence and adulthood (Bryant-Waugh & Kaminski, 1993). Some authors (Alessi et al., 1989; Fosson et al., 1987) argue that the clinical characteristics are essentially the same (e.g., typical reasons for food refusal include fears of fatness; and similar concerns about body appearance are expressed). Other authors (Gowers et al., 1991) argue that many characteristics (e.g., primary amenorrhea; precipitants such as anxieties about pubertal development) distinguish this group from post-pubertal groups. Gowers et al. (1991) state that while prepubertal anorexics tend to end up as severely afflicted (at presentation) as post-pubertal groups, they do not as frequently resort to purging (e.g., laxative abuse) in

order to lose weight. Jacobs and Isaacs (1986) found differences in feeding histories of pre-pubertal anorexics in comparison to a pre-pubertal neurotic group and post-pubertal anorexic group; the pre-pubertal anorexic group had evidenced significantly higher levels of childhood feeding difficulties and mealtime difficulties; family members also evidenced significantly higher levels of feeding difficulties and food fads. Irwin (1984) states that in children, depressive symptoms appear to occur earlier, and the question has been raised as to whether childhood onset anorexia nervosa is a variant of childhood depression.

According to Irwin (1984) one of the specific problems encountered in childhood anorexia is that children generalise their pathologic food intake to include fluid intake. Irwin states that because of their concrete cognitive level, they believe that water is as likely (as food) to lead to weight gain. The restriction of fluid intake contributes to faster deterioration in children with anorexia nervosa (Irwin, 1984). In addition, younger children appear to deteriorate more rapidly due to the fact that they have less body fat than older girls (Irwin, 1984). They thus become emaciated more rapidly. Irwin found that two thirds of children required hospital admission less than six months after they began to diet.

One of the major and critical consequences of childhood anorexia nervosa is that weight loss both reverses and halts the pubertal process/growth (Fosson, de Bruyn, & Thomas, 1993; Gowers et al., 1991). Gowers et al. (1991) state that the role of anorexia nervosa in delaying puberty is well-established. Russell (1985) followed up 20 girls with premenarcheal anorexia nervosa in order to determine the impact thereof on puberty. The follow-up period ranged from 3 to 27 years. It was found (Russell, 1985) that early onset anorexia nervosa caused a prolonged delay of puberty (late menarche); in some cases, it interfered permanently with growth in stature and breast development. In terms of the long-term impact, Russell states that in those cases where the illness results in ongoing malnutrition over several years (including the time of puberty), the breasts may fail to appear and menstrual function may be delayed until the mid-twenties. Fosson et al. (1987), in a study of treatment outcome, found that most patients improved during admission (68% achieved all therapeutic goals). Fosson et al. (1987) state that while 80% of the group made significant weight gains, problems remained in one or more psychosocial areas. Higgs et

al. (1989) state that the outcome for children in their study was not good, however, it was similar to that of older patients. According to Bryant-Waugh (1993b) there have been few studies of the outcome of anorexia nervosa in children; in the few studies which do exist, methodological problems are evident. Bryant-Waugh states that overall, the outcome in children appears to be as variable as that in older patients. Good prognostic indicators include young age at hospitalisation, together with a short duration of symptoms (Bryant-Waugh, 1993b).

In terms of the definition of pre-pubertal anorexia nervosa, in some cases early onset anorexia nervosa is defined as occurring before the age of 15; other reports refer to pre-pubertal and pre-menarcheal children (Bryant-Waugh, 1993a). Various authors point out that pre-menarcheal is not the same as pre-pubertal due to the fact that menarche is a fairly late event in the pubertal process (Gowers et al., 1991; Kent, Lacey, & McCluskey, 1992; Russell, 1985). Gowers et al. (1991) state that secondary sex characteristics may be preceded by prepubescent changes in fat distribution and oestrogen levels, by up to three years. Nielsen (1985) in a study of 66 anorexics found that in females, peak height velocity had occurred at 11.5 years and menarche (on average) 1.34 years thereafter. Various authors state that the occurrence of anorexia nervosa in children (i.e., a demographically atypical group) suggests pathology outside of the presumed aetiological factors (e.g., pubertal and adolescent conflicts) (Alessi et al., 1989; DiNicola et al., 1989; Gowers et al., 1991). It is argued (Alessi et al., 1989; Gowers et al., 1991) that childhood presentations challenge theories regarding the role of pubertal processes in the aetiology of the illness. Gowers et al. (1991) state, however, that it could be argued that the anorexic pre-pubescent girl's weight controlling behaviour is in anticipation of, rather than in response to puberty. Various authors (Fosson et al., 1987; Fundudis, 1986) state that more research is needed on the clinical features of children, as these have not been as researched as those of older patients.

Physical Factors

Sequelae of starvation

Starvation has clear physical sequelae including emaciation and poor circulation (evidenced in slow, weak pulse; low blood pressure; cold hands/feet; and discoloured skin) (Bryant-Waugh & Lask, 1995). Lanugo hair (a fine downy hair) is a further manifestation of physical starvation (APA, 1994; Bryant-Waugh & Lask, 1995). Physical complications of anorexia nervosa may include hypothermia; cardiac failure; electrolyte disturbances; and osteoporosis (Hartman, 1995). Amenorrhea also occurs with starvation. However, there are suggestions (Garfinkel & Garner, 1984; Miles & Wright, 1984) that in anorexia nervosa, psychological factors (adolescent conflict; emotional upheaval) may be partly implicated in amenorrhea, as evidenced by the number of cases in which amenorrhea appears to precede weight loss (Garfinkel & Garner, 1984). Some studies (Krieg et al., 1986) report cortical pseudoatrophy in anorexic patients although this to some extent appears to be reversible with weight gain.

In addition to the physical sequelae of starvation, various psychological manifestations of physical starvation have been described (APA, 1994; Dare, 1993) independently of the origin of starvation (i.e., self-starvation; famine; war situations). These include depressed mood; mood lability; cognitive impairments; social withdrawal; an intense preoccupation and interest in food; hoarding food; and eating extremely small portions of food at a time - in an apparent attempt to make the meal last (APA, 1994; Dare, 1993; Garfinkel & Garner, 1982; Garfinkel & Kaplan, 1986; Hsu, 1983; Strober, Lampert, Morrell, Burroughs, & Jacobs, 1990).

Biological Theories

The brain plays a pivotal role in regulating food intake (Leibowitz, 1986) and biological theorists have proposed that a biological vulnerability may be present in persons with anorexia nervosa (Halmi, 1986). Casper (1986a) states that various interacting systems

are involved in the control of hunger and satiation. These include the neuronal transmitter systems, the gastro-intestinal system and the opioid peptide hormone system (Casper, 1986a). Biological theorists have postulated as causative, primary hypothalamic dysfunction; pituitary dysfunction; disturbed resting metabolic rate; and disturbances in the biochemistry of appetite/eating, for example, the detection of satiety (Crisp, 1995; Halmi, 1986; Hartman, 1995; Hsu, 1983). Some studies implicate the hypothalamic-pituitary-adrenal axis (Cavagnini, Invitti, Passamonti, & Polli, 1986; Ferrari et al., 1986); changes in the hypothalamo-pituitary-thyroid axis have been reported following weight loss or reduced caloric state (Fichter & Pirke, 1986).

Neurotransmitters, such as dopamine and serotonin, have also been proposed to play a role in anorexia nervosa (Hartman, 1995). Noradrenaline, endogenous opiates and peptides have similarly been implicated (Hartman, 1995). Serotonin, in particular, has received a great deal of attention (Crisp, 1995; Hartman, 1995). Serotonin is implicated in sleep, pain, appetite, the stress response, mood, sexual and reproductive function, as well as the psychobiology of various affective disorders (Hartman, 1995; Reber, 1985). Gender differences in serotonin function in humans, have been found (Hartman, 1995). Serotonin appears to play a role in the suppression of food intake; nutrient selection (favouring carbohydrates); feeding; satiation; and the regulation of body weight (through thermogenesis and activity) (Hartman, 1995; Lanzola & Savoldi, 1986). Many of the neurotransmitters are diet-dependent (Erdmann & Jones, 1987; Lanzola & Savoldi, 1986). It is thus not clear whether disturbed neurotransmitter functioning is secondary or causative in disturbed eating (Hartman, 1995). Psychopharmacological drugs have not been found to be superior to placebo in the treatment of anorexia nervosa (Casper, 1986a) and according to Hartman (1995) there is little current support for the use of pharmacological treatments. Various authors (Apfelbaum, 1986; Casper, 1986a) propose that the best physical treatment for anorexia nervosa is food.

Psychological Factors

Individual psychological factors proposed to be associated with anorexia nervosa, such as difficulties negotiating the developmental changes associated with puberty, will be discussed below. Psychodynamic formulations of anorexia nervosa have connected these difficulties to the mother-child relationship. Anorexia nervosa is considered to stem, in part, from problematic early object relations (mother-child interactions) specifically in relation to autonomy and separation/individuation. Personality traits which may predispose to anorexia nervosa will also be considered below. Finally, treatment considerations in individual psychotherapy will be discussed.

Developmental Factors

Anorexia nervosa frequently occurs at puberty. The timing of the illness has led a multitude of theorists to postulate that anorexia arises in response to difficulties coping with the developmental demands of puberty, such as sexual maturation and the establishment of a separate and autonomous identity (Crisp, 1995; Crisp, Norton, Jurczak, Bowyer, & Duncan, 1985; Dittmar & Bates, 1987; Jeammet, 1981; Strober & Bowen, 1986). Anorexia is regarded as an attempt to resolve pubertal conflicts by avoiding growing up as evidenced in the regression to a child-like physical state (Crisp et al., 1980; Dare, 1993; Dittmar & Bates, 1987; Jeammet, 1981; Plaut & Hutchinson, 1986; Romeo, 1984).

Crisp (1995) states that puberty is not "asked for" and may thus be experienced as ego dystonic. Puberty is, according to Crisp linked to body weight (and "fat") at the 40 to 45 kilogram level. Crisp (1995) states that most anorexics regard their ideal weight as being about 41-44.5 kilograms. In Crisp's view, anorexia nervosa arises from the fear (and avoidance) of "fatness" associated with the normal mature female body. Various studies (De Castro & Goldstein, 1995; Ohzeki, Otahara, Hanaki, Motozumi, & Shiraki, 1993) indicate that girls show increased concerns with eating as they get older. De Castro and Goldstein (1995) compared prepubertal with postpubertal females and found that females at 12 and 13 years became concerned with both the increase in weight, as well as their body

shape. In addition, the postpubertal group evidenced greater body dissatisfaction, a more negative body image and more restraint of eating, than the prepubertal group.

One of the major concomitants of pubertal bodily changes (albeit a late event in the pubertal process) is the commencement of menstruation. Many authors (De Beauvoir, 1952; Deutsch, 1944; Romeo, 1984) have commented upon the fact that menstruation may be experienced as an abrupt and frightening event. Deutsch (1944, p. 149) states that the first menstrual period "mobilises psychic reactions so numerous and varied that we are justified in speaking of the psychology of menstruation as a specific problem". Menstruation may evoke inter alia, fantasies of loss of bodily control which may evoke earlier conflicts regarding infantile dependence and independence in relation to the mother, centred around issues of autonomy and control (Whisnant & Zegans, 1981). Deutsch (1944) states that the young girl's perception of being out of control of her bodily/ eliminative functions may also lead to intense anxieties of a phobic nature regarding bodily function (Deutsch, 1944).

Amenorrhea is one of the primary diagnostic features in anorexia nervosa (APA, 1994). Studies (Miles & Wright, 1984) suggest that amenorrhea occurs partly as a psychobiological defence against adolescent conflict. Ushijima and Kobayashi (1988) report that anorexic patients presenting prior to menarche have been found to evidence anxieties about menarche. Various authors (Becker et al., 1981; Plaut & Hutchinson, 1986) have commented upon the difficulties anorexic patients experience in coping with physical pubertal events, such as menarche. As mentioned above, early theorists (Deutsch, 1944) proposed that menarche may raise issues regarding control and autonomy. The struggle for control has been regarded as a central feature in anorexia nervosa (APA, 1993; Bruch, 1978; Crisp, 1995; Dittmar & Bates, 1987; Hogan, 1983a, 1983b; Mintz, 1983a; Romeo, 1984; Sours, 1980). Swain, Shisslak, and Crago (1991) found that the cession of menses was associated with an enhanced sense of personal control - albeit transient. The question does arise as to whether one of the major underlying conflicts in the illness pertains to the event of menstruation in terms of the psychological conflicts (bodily control; autonomy) evoked by menstruation. Mintz (1983b) proposes that anorexics starve themselves into

amenorrhea in order to cope with the conflicts evoked by menstruation. As mentioned, such conflicts (associated with bodily control) may evoke unresolved issues regarding autonomy.

Difficulties regarding separation and autonomy are regarded as one of the central psychological features of anorexia nervosa. Various authors (Becker et al., 1981; Bruch, 1978; Evans & Street, 1995; Farrell, 1995; Plaut & Hutchinson, 1986) state that one of the main problems of the anorexic is the struggle for and achievement of autonomy, as well as a differentiated sense of self. It has been proposed (Evans & Street, 1995; Plaut & Hutchinson, 1986) that anorexics evidence ego deficits associated inter alia, with developmental arrests at the symbiotic separation-individuation phase, which render it difficult to cope with the second major separation-individuation phase which occurs at puberty. Bruch (1978) regarded separation-individuation arrests as one of the central psychological characteristics of "restricting" anorexics whom she considered to be primary anorexics. Bruch proposed that these early arrests led to an inability to establish clear self-object boundaries and autonomy. Bruch postulated that the inability to establish a differentiated sense of self stemmed from deficits in early relational experiences, in that a sense of effectiveness was never instilled in the child in relation to his/her physical needs (Bruch, 1978). The child was never accorded the opportunity to identify hunger and internal responses correctly as these were imposed externally by the mother (Bruch, 1978). Such experiences resulted in cognitive disturbances in the interpretation of internal bodily states, as well as a disturbed body image and an "all-pervasive" sense of ineffectiveness (Bruch, 1978, p. 39).

Dare (1993) also proposes that the mother-daughter relationship is connected to the difficulties anorexics experience with separation and individuation. Dare states that separation is experienced as a "desperate betrayal" (p. 19) of her parents and self-starvation is one way of asserting separateness. Dare says that "without the self starvation her individuality would be killed. The paradox of starving herself to death to save herself, is confusing but central" (p. 19). It has been proposed (Jeammet, 1981) that separation

threatens the narcissism of the anorexic. Similarly, maternal narcissism has been implicated in the separation difficulties (Farrell, 1995; Plaut & Hutchinson, 1986; Sayers, 1988).

Various authors (Maine, 1991; Sayers, 1988) have criticised the focus of psychodynamic theories, upon the mother as the origin of the anorexic's problem. It is argued (Maine, 1991) that such formulations neglect the father-daughter relationship which in itself, has a critical impact on the daughter's body image. It has also been argued that psychodynamic theories neglect the impact of socio-cultural factors, such as patriarchal social structures, which have contributed to the development of overly close and involved mother-daughter relationships (Sayers, 1988; Theriot, 1988).

According to Hsu (1983) one of the central difficulties with psychodynamic formulations is that these have not been empirically tested. The developmental demands of adolescence do, however, appear to play a pivotal role in the emergence of anorexia nervosa. According to Rosenbaum (as cited in Plaut & Hutchinson, 1986) adolescence requires that the girl consolidate her sense of femininity through identification with her mother but at the same time establish a separate identity. Norris (1979) points out that adolescence is marked by conformity to peer-group fashion, as well as extreme body-consciousness. This in itself, may predispose towards eating disorders given the current fashion of thinness.

The main focus of the above discussion has been upon object-relations theories of anorexia nervosa. Earlier psychoanalytic theories suggested that anorexia nervosa occurred as a response to pubertal sexual maturation and represented a regression to earlier oral patterns (Peake & Borduin, 1977). Such theories proposed that eating was imparted with sexual significance and the rejection of food was considered to arise from fantasies of oral impregnation (Dare, 1993; Dittmar & Bates, 1987; Jacobs & Isaacs, 1986; Mynors-Wallis, 1989; Sayers, 1988). Unresolved oedipal conflicts were regarded as critical in the anorexic's difficulties coping with psychosexual development (Sperling, 1983).

Personality Factors

Early clinicians, such as Collins (1894, p. 202) proposed that the "perverted ego" as evidenced inter alia in a "gloomy self-concentration" was both the cause and central feature of anorexia nervosa. Psychodynamic theorists postulate that anorexics evidence severe structural ego defects and character pathology - including the reliance upon primitive defences such as splitting, denial and projection (Chessick, 1989; Plaut & Hutchinson, 1986). Chessick (1989) proposes that an intense narcissistic rage underlies the anorexic disturbance. Crisp (1995) considers anorexia nervosa to be a variant of the phobic-avoidant disorders. Various authors regard the "delusions" manifested in the anorexic's distorted body image as "psychotic-like" and reflective of the severity of the anorexic disturbance (Dare, 1993; Jeammet, 1981; Selvini-Palazzoli, 1985b). From an object-relations perspective, Selvini-Palazzoli (1985b) considered anorexics to evidence an intrapsychic paranoid split, such that they were midway between the paranoid-schizoid and depressive positions.

Eating disordered women have been found (Swain et al., 1991) to report oddities of thought and depressive symptoms. Swain et al. found that eating disordered women scored higher on certain scales of the MMPI, suggesting higher levels of depression and schizophrenic-like symptomatology, as compared to a normative sample (Swain et al., 1991). Garfinkel and Garner (1984) state that there are few empirical studies of the psychological characteristics of anorexics. Various reports, however, suggest that certain personality features are common in anorexics. These features include obsessive-compulsive traits; compliance; dependence; shyness; conscientiousness; conflict avoidance; helplessness; feelings of ineffectiveness; deficits in self-esteem; reliance of self-esteem upon external performance and appearance; and disparities between perceived self and ideal self (APA, 1993; Bruch, 1978; Bryant-Waugh & Lask, 1995; Crisp et al., 1980; Miles & Wright, 1984; Norris, 1979; Schwartz & Barrett, 1987). In addition, anorexics have been reported to lack interoceptive awareness (i.e., the ability to interpret inner sensations), as well as difficulties in tolerating, recognising and regulating affective states (APA, 1993;

Garfinkel & Garner, 1982). The lack of interoceptive awareness has been found to be a risk factor for the development of eating disorders (Leon, Fulkerson, Perry, & Cudeck, 1993).

Specific cognitive disturbances evidenced in anorexics include: the narrow scanning of information; repression; selective abstraction; over-generalisation; all or none reasoning; magnification; self-reference; and magical thinking (Heilbrun & Harris, 1986; Mynors-Wallis, 1989). Garfinkel and Garner (1982) state that anorexics often evidence "faulty" assumptions such as, the belief that thinness is the sole basis for self-worth; that complete control is necessary; and perfection should be striven for.

Individual Psychotherapy

Psychotherapy with anorexics is regarded as difficult for various reasons, including the anorexic's lack of insight and associated lack of motivation for treatment (Colahan, 1995). Colahan describes her adolescent patients as often arriving for therapy "literally or metaphorically kicking and screaming" (p. 91). The lack of motivation for treatment frequently hampers the task of establishing a therapeutic relationship, which is in itself one of the most difficult and critical aspects of work with anorexics (Becker et al., 1981; Crisp et al., 1985; Garfinkel & Garner, 1982; Vandereycken, 1987). Factors such as the adolescent's drive towards independence and the anorexic's mistrustful approach to others may contribute in part, to the difficulties establishing a working alliance (Becker et al., 1981; Garfinkel & Garner, 1982).

Other factors which pose difficulties for psychotherapy include the anorexic's tendency towards pre-verbal concrete thinking, as well as the anorexic's silence and reluctance to talk (Alessi et al., 1989; APA, 1993; Bruch, 1978; Colahan, 1995; Evans & Street, 1995; Farrell, 1995; Fundudis, 1986; Magagna, 1993; Sayers, 1988; Steinhauer, 1984). Colahan (1995) states that the anorexic will frequently "sit silently, stubbornly, miserably, for session after session and the therapists will experience the same frustration as the parents do when their child resolutely refuses to take in the lifegiving food" (p. 81). There are reports of such silences continuing throughout lengthy therapies (Colahan, 1995).

Birksted-Breen (cited in Farrell, 1995) in her description of a silent patient, wrote "I sometimes had the fantasy that she and I were buried in a tomb of silence for eternity" (p. xiv). Farrell's book was named *Lost for words* partly to convey the centrality of this problem in the anorexic experience. Farrell (1995) states that:

> words are as, if not more, problematic for women with eating disorders than their relationship to food. They are either seen as a useless form of communication, or as being so tremendously powerful that they may drown in them, or be torn to pieces by them. (p. xiv)

The anorexic's difficulty with the verbalisation of her experiences does not appear to be associated with limited language capacity (Alessi et al., 1989). Rather, such difficulties appear to be linked to the anorexic's tendency to use "action language" and "body language" (i.e., somatise conflicts) as opposed to verbal language (Jeammet, 1981; Romeo, 1984). Farrell (1995) states that finding and using words requires the recognition of the presence of the other as a separate person. Difference has to be acknowledged and the difficulty for the anorexic is that she wants to remain in a fantasy state of fusion (Farrell, 1995). One of the major therapeutic tasks is finding a way of dealing with the silence. Colahan (1995) reports using various strategies, such as allowing the patient to be silent; limiting the session to a few minutes and giving the patient the option of choosing more time if she so desires; as well as wondering out loud what the silence might mean and what might be going on for the patient. In addition, various clinicians have utilised non-verbal therapies (e.g., art therapy; music therapy; drama therapy; movement therapy) and found these to be useful (APA, 1993; Dokter, 1995).

Treatment Outcome

Bryant-Waugh and Lask (1995) state that there have been no studies demonstrating benefits from long-term individual therapy. Also, according to Mynors-Wallis (1989) there have been few empirical studies comparing the effectiveness of different psychodynamically oriented therapies. The Maudsley trials (to be discussed in greater detail

in the family section) failed to indicate the superiority of individual therapy to family therapy (Dare et al., 1995). Dare et al. state that in those cases in which individual therapy was beneficial, therapists and patients had succeeded in forming a therapeutic alliance. Becker et al., (1981) in an outcome study of adolescent patients, two to five years after they had received analytically-oriented therapy (on average for three months), found a very good to satisfactory outcome for 56% (physically and psychosocially); 16% still had marked symptoms; 13% had died; and a further 16% of the sample could not be traced.

Various authors (Bryant-Waugh & Lask, 1995; Mynors-Wallis, 1989) state that behavioural programmes remain controversial, and that there is little evidence for the efficacy thereof. Cognitive-behavioural programmes do, however, appear to promote healthy eating behaviours and effective coping (Bryant-Waugh & Lask, 1995). Robin, Siegel, Koepke, Moye, and Tice (1994) in a controlled randomised study (of out-patient adolescent girls) compared behavioural family systems therapy with ego-oriented individual therapy (over one and half years). Robin et al. (1994) found that both types of therapy produced similar levels of positive change in eating attitudes, body dissatisfaction, depression, and family conflict. The behavioural programme was found to be more successful than ego-oriented individual therapy in terms of weight gain.

In conclusion, few empirical studies comparing the efficacy of different kinds of individual therapies, exist. However, individual therapies have been found to be effective in clinical practice (Mynors-Wallis, 1989). It needs to be remembered, however, that the treatment of anorexia nervosa is difficult (Selvini-Palazzoli, 1985b). Apfelbaum (1986, p. 280) suggests that each therapist allow themselves a measured span of time to obtain a cure or improvement following which, he advises "if you did not succeed, let others try".

Family Systems

Family theorists (Minuchin et al., 1975; Minuchin, Rosman, & Baker, 1978; Selvini-Palazzoli, Cirillo, Selvini, & Sorrentino, 1989) have focused on patterns of family functioning in families with an anorexic member. Family approaches to anorexia nervosa

emphasise that the individual cannot be understood in isolation from his/her context (Selvini-Palazzoli et al., 1989). Family systems theorists focus on feedback processes, as well as patterns and connections between the individual and his/her context (Keeney & Ross, 1992; Minuchin et al., 1975).

Structural Theories

Minuchin et al. (1975) and Minuchin et al. (1978) focused on the structural characteristics and transactional patterns of families with psychosomatic (asthmatic, diabetic and anorexic) members. These authors distinguished between primary and secondary psychosomatic conditions (Minuchin et al., 1975; Minuchin et al., 1978). The former entailed the exacerbation of a pre-existing physiological vulnerability/organic condition through emotional arousal whereas the latter, for example anorexia nervosa, involved the transformation of emotional conflicts into somatic symptoms (Minuchin et al., 1978).

Minuchin et al. (1975) and Minuchin et al. (1978) postulated that family interactional processes associated with psychosomatic illnesses included the triangulation of the sick child in parental marital conflict, as well as the following patterns of family functioning: (1) enmeshment; (2) over-protectiveness; (3) rigidity; and (4) lack of conflict resolution. Enmeshed families were characterised by weak sub-system boundaries and intrusion across boundaries, as well as a lack of differentiation between self and others (Minuchin et al., 1975; Minuchin et al., 1978). Excessive cohesiveness and specific communicational styles (e.g., blocking direct communication; interrupting communications) were also indicative of enmeshment (Minuchin et al., 1975; Minuchin et al., 1978). Over-protectiveness in these families impeded the development of autonomy in family members and rigidity manifested in difficulty adapting to change and growth associated, for example, with normal developmental phases such as adolescence (Minuchin et al., 1975; Minuchin et al., 1978). Furthermore, these families evidenced a low tolerance for conflict and poor conflict resolution (Minuchin et al., 1975; Minuchin et al., 1978). The latter was associated with different methods of conflict avoidance: (1) conflict detouring in which parents united in concern (or blame) for the sick child; (2) triangulation; and (3) parent-child coalitions in

which the sick child was pushed to side with one parent (Minuchin et al., 1975; Minuchin et al., 1978). Minuchin et al. (1975) and Minuchin et al. (1978) postulated that the symptom played an important role in maintaining family homeostasis. It was also noted that these families were developmentally inappropriate in terms of the control of individual members' psychological and bodily functioning (Minuchin et al., 1975). In addition, self-sacrifice and loyalty were of paramount importance in these families.

The treatment focus in Minuchin et al. (1975) and Minuchin et al.'s (1978) work was on changing family processes associated with the precipitation and maintenance of symptoms. Interventions included supporting sub-system definition; as well as challenging enmeshment, over-protectiveness and conflict avoidance (Levenstein, 1981; Minuchin et al., 1975; Minuchin et al., 1978). Minuchin et al. (1975) reported "dramatic" results in the treatment of anorexia nervosa using a systemic approach. Various authors (Stierlin & Weber, 1989; Vandereycken, 1987) have argued that certain characteristics (young age of patients; intact families; short duration of illness) which have a positive impact on outcome, may have contributed to Minuchin's very high success rate.

Some studies (Fosson et al., 1987; Harper, 1983; Norris, 1979; Schwartz & Barrett, 1987) report similar findings to those of Minuchin in terms of family interactional patterns (enmeshment, communication problems, overprotectiveness, difficulties with conflict). However, various authors (Grigg & Friesen, 1989; Hall, 1987; Mynors-Wallis, 1989; Vandereycken, 1987) state that recent research has not validated Minuchin's model of family functioning and that families with anorexic members have been found to be heterogeneous. Feminists have in addition pointed out that structural theories neglect the role of the wider social context in the emergence of eating disorders, specifically in women (Mirkin, 1990). Auerswald (1990) states that conceptualisations of events which lead to distress within families, must include events which occur beyond the family (e.g., in social system). Auerswald regards relational disconnection as a central aetiological factor in the onset of symptomatic behaviour. He defines two kinds of hunger: (1) somatic which occurs due to physical nutritional deprivation; and (2) relational hunger which occurs due to relational disconnections. According to Auerswald relational "malnutrition" may result

in psychiatric symptoms, including "psychosis". In individuals in whom relational hunger begins in the formative years, relational skills are never developed (Auerswald, 1990). During times of stress, such individuals tend to withdraw and reify internal dialogues (Auerswald, 1990). Johnson (1993) in an analysis of Kafka's *The metamorphosis*, comments on the relational hunger which food-refusing (self-starving) persons manifest; such hunger is often overlooked by persons within their environments.

Strategic Theories

Selvini-Palazzoli's (1985a) approach to anorexia nervosa was based on cybernetics and communication theory. Selvini-Palazzoli argued that social norms (ideals of thinness) together with specific kinds of family functioning led up to a "deadly family game" (p. 15) involving anorexia nervosa, through which the anorexic child found a way of bringing her "parents to their knees" (p. 15). These families were characterised by parental overcontrol and escalating symmetrical processes in relation to the control of food (Selvini-Palazzoli, 1985a). Competitive sacrificial symmetry was, however, also characteristic of the parental relationship prior to the onset of symptoms (Selvini-Palazzoli, 1985b). The parents presented as a happy and stable couple to the outside world; however, this facade masked a deep disillusionment and disappointment within the marriage, as well as competitiveness around who had been the greater martyr in the marriage (Hsu, 1983; Selvini-Palazzoli, 1985b). This competitiveness manifested in escalating symmetrical processes in which the child became entangled, due to family rules prohibiting the seeking of allies outside of the family (Hsu, 1983; Selvini-Palazzoli, 1985b). Selvini-Palazzoli stated that various patterns were characteristic of such families, for example, blame-shifting; an emphasis on self-sacrifice and loyalty; as well as the right to reject what was offered (e.g., messages; definitions of relationships; or concrete objects, such as food). In addition, there were prohibitions against (1) the assumption of leadership positions within the family; and (2) the establishment of overt alliances, since any overt alliance between two persons was viewed as a betrayal against a third (Selvini-Palazzoli, 1985b).

Selvini-Palazzoli et al.'s (1989) initial treatment approach to anorexic families was based on the Milan model and incorporated the use of the hypothesis, positive connotation and paradox, the purpose of which was to link symptoms with marital difficulties. The standard use of the paradox was, however, later found to be unsatisfactory and abandoned (Selvini-Palazzoli et al., 1989), partly because Selvini-Palazzoli et al. were "staggered by the bewildering plethora of variables accruing to each family" such that they were "utterly unable to distinguish an unvarying, common pattern" in these families (Selvini-Palazzoli & Viaro, 1988, p. 130). Following the abandonment of the paradox, Selvini-Palazzoli et al. adopted the invariant prescription, which in essence focused on the definition and establishment of sub-system boundaries with a view to disentangling the daughter from the parental marital relationship. Selvini-Palazzoli and Viaro (1988) posed a six stage model describing processes in the anorexic family. These processes led up to an "imbroglio", the family game alluded to above, which entailed a complex interactional sequence precipitated and maintained by the need to preserve, as privileged, a trans-generational alliance between mother/daughter or father/daughter (Selvini-Palazzoli & Viaro, 1988; Speed, 1995). Selvini-Palazzoli and Viaro (1988) postulated that the young anorexic girl-to-be gets caught up in a stalemate in the parental relationship, following which a close covert alliance with either parent is established. At adolescence, the mother re-invests the special love previously shown to her daughter, elsewhere. The girl, feeling betrayed forms a "seductive bond" with her father. Following a further incident of relational distress (usually involving her mother), the girl begins to diet in an attempt to distance and differentiate herself from her mother while identifying with her peer group. Selvini-Palazzoli and Viaro (1988, p. 133) describe the dieting as a "silent protest and rejection of the mother". Dieting, however, initiates an interactional spiral in the triad, the father does a "volte face" and the girl, feeling angry and let-down, escalates her food restriction (Selvini-Palazzoli & Viaro, 1988). According to Selvini-Palazzoli and Viaro the family game comes to include symptom-based strategies, which are very powerful and allow the girl to recapture her special place (which she held as a child) as the object of maternal attention and concern. However, what appears to be a special trans-generational alliance is "nothing of the sort" and in fact masks a great deal of conflict and hostility (Selvini-Palazzoli & Viaro, 1988, p. 133).

Selvini-Palazzoli's (Selvini-Palazzoli, 1985a, 1985b; Selvini-Palazzoli & Viaro, 1988) contributions included inter alia, demonstrating the role of the symptom as a strategy within the dysfunctional family (Vaz-Leal & Salcedoe-Salcedo, 1995). The positive connotation of the symptom as sacrificial, altruistic and protective of the family, was according to various authors (Schwartz, 1987; Vandereycken, 1987) of value to clinicians in preventing symmetrical "fights" with the family in therapy. Some reports (Becker et al., 1981; Schwartz, 1987) describe similar observations to those of Selvini-Palazzoli in terms of family emphases on loyalty, however, as was the case with Minuchin's work, a major criticism of Selvini-Palazzoli's work has been that families with an anorexic member are heterogenous and that multidimensional models are needed in treatment (Hall, 1987; Vandereycken, 1987).

White (1983, 1989) using a cybernetic theoretical framework similar to that of Selvini-Palazzoli's, has commented on the frequency of repetitive guilt/blame cycles, as well as the injunctions regarding loyalty in families with an anorexic member. White (1983, 1989) states that family beliefs and rules constrain the choices which individuals are able to make thus making it difficult, for example, to be autonomous and independent. Such family rules, coupled with gender stereotypes (women should subjugate their needs to others) establish a vulnerability in the daughter which together with social norms (ideals of thinness) creates a context for the manifestation of anorexia nervosa (White, 1983, 1989). White (1983) also comments on the apparent "insight" in such families who "see" and "know" what underlies the anorexia nervosa. According to White (1983, p. 258) such insight contributes to the family members remaining "tightly glued" together in self-criticism and blaming.

The above-mentioned family-oriented therapists advocated that family therapy was highly effective and mandatory in the treatment of anorexia nervosa. Hsu (1983) states that early clinicians, such as Charcot and Lasegue also commented upon the family dysfunction characteristic of families with an anorexic member. It has however, been pointed out that it is not clear whether the observed dysfunctional patterns within such families pre-date the anorexia or follow upon the manifestation of symptoms (Bryant-Waugh & Lask, 1995;

Hsu, 1983; Norris, 1979). Vandereycken (1987) states that not all families with an anorexic member are dysfunctional and that anorexic behaviour can in itself lead to disturbed interactional patterns. Snyders (personal communication, April 24, 1998) states that problem-determined systems are formed as a result of the onset of the behaviour. Various authors (Stierlin & Weber, 1989; Vandereycken, 1987) argue that family therapy is not necessary in all cases. It has also been argued (Lockwood, 1986; Speed, 1995) that individual therapy is frequently needed over and above any family therapy.

The Maudsley trials investigated the effects of psychotherapy in randomised controlled trials (Colahan, 1995; Dare et al., 1995). Family therapy (FT) was found to be superior to individual supportive therapy only in young patients (less than 19 years old) with symptoms of short duration (less than three months) (Dare et al., 1995). At follow-up (five years), 90% of those who received FT were well, whereas 50% of those who received individual therapy still had an eating disorder. Trial 2 of the study, compared FT with brief focal psychoanalytic therapy and individual supportive therapy - in patients over the age of 18; again FT patients did better on the whole than individual therapy patients, although this was particularly so for patients whose illness began in their teens. Trial 3 compared conjoint FT with family counselling (parents and patients seen separately in symptom-focused and problem-solving therapy) in adolescent patients with no prior hospitalisation; the two treatments were equally effective but family counselling was superior to FT in families with high levels of "expressed emotion" (excessive parental criticism) which in itself, was found to be predictive of poor outcome. According to Dare et al. the Maudsley trials indicated that FT works best with young early onset (soon after puberty) patients with a short duration of symptoms. In these cases, FT was found to have long-term benefits in five year follow-up studies. In addition, Dare et al. state that the efficacy of the parental counselling model indicated that family therapy can successfully be combined with individual therapy.

Various authors (Mirkin, 1985; Speed, 1995; Vandereycken 1987) state that the origin of eating disorders is complex and multifactorial, necessitating a multidimensional approach. Vandereycken (1987, p. 461) has criticised the "hocus pocus" tricks and

"ruthless, manipulative and paternalistic styles" of some strategists and structuralists arguing that these do not take into account the multifaceted nature of anorexia nervosa. In addition, ethical concerns regarding the use of paradox in a life threatening illness have been raised (Vandereycken, 1987). Snyders (personal communication, April 24, 1998), however, points out that not all family therapies use paradoxical techniques. Nonetheless, concern has also been voiced that parents/families may feel blamed in family therapy and it needs to be remembered that not all families are pathological (Gilchrist et al., 1986; Mynors-Wallis, 1989; Vandereycken, 1987). Psychological approaches, including family therapy, which imply parental blame may increase the distress parents experience regarding the illness of their child. Gould (1993) and MacDonald (1993) have described the parental distress associated with a food refusing child. Vandereycken (1987) states that while family therapists reminded clinicians that patients do have families, some family therapists tend to forget that patients also have bodies. Vandereycken calls for a more respectful approach to families, one which assumes that they "have tried their best...but are tired...and want help" (p. 465) as opposed to uncritically assuming pathology.

Not all families with an anorexic member demonstrate the pathology observed by Minuchin and Selvini-Palazzoli. Speed (1995, p. 7) states that "even if family dysfunction is present, it cannot be concluded that this is causative rather than conceptual" and it needs to be remembered that "they did not intend to be not good enough parents, they did not intend to live in an imbroglio...but that is somehow how it turned out". Finally, family therapists have been criticised for failing to validate their techniques empirically, as well as lacking a sense of self-criticism and reporting their successes but not their failures. Vandereycken (1987, p. 465) calls for a greater "scientist-practitioner" spirit among family therapists which he describes as the "fusion of the creativeness of the artist, the skilfullness of the clinician, and the self-criticism of the researcher".

Family Psychiatric Illness

Families with an anorexic member appear to have higher rates of psychiatric illness, particularly depression, anxiety and alcoholism (Crisp et al., 1980; Fosson et al., 1987;

Garfinkel & Garner, 1984; Jacobs & Isaacs, 1986; Strober et al., 1990). Strober et al. (1990) found significantly higher rates of affective disorders in the families of anorexics *with* co-existing depression. DiNicola et al. (1989) state that it is not clear whether the familial occurrence of anorexia nervosa and affective disorder is genetically connected. Some studies (Strober et al., 1990) suggest independent transmission for the two disorders.

Familial Eating Disorders

Various studies and reports have documented the presence of eating disorders and weight disorders in family members of anorexic patients (Alessi et al., 1989; Crisp et al., 1980; DiNicola et al., 1989; Fosson et al., 1987: Hall, 1987: Jacobs & Isaacs, 1986; MacDonald, 1993; White, 1983). Such disturbances have been noted in first degree relatives, as well as second-degree relatives, who (in the past or at the time of the study) had chronic anorexia, probable anorexia, or developed anorexia or obesity subsequent to treatment of the primary anorexic member (Alessi et al., 1989; Crisp et al., 1980; DiNicola et al., 1989; Fosson et al., 1987; Hall, 1987; Jacobs & Isaacs, 1986). Treatment was not always sought for other family members (Crisp et al., 1980).

Twin studies and familial studies suggest a familial influence in the occurrence of anorexia nervosa. Monozygotic twins evidence higher concordance rates than dizygotic twins and about 5% of first degree relatives appear to be afflicted with anorexia nervosa (APA, 1993; Bryant-Waugh & Lask, 1995; Crisp, 1995; Holland, Sicotte & Treasure, 1988; Strober et al., 1990).

Holland et al. (1988) found a 56% concordance rate in female monozygotic twin pairs and a 5% concordance rate in dizygotic twin pairs. In addition, nearly 5% of first degree female relatives had a history of anorexia nervosa, which is much higher than estimated prevalence rates (less than 1%) in the general female population. Holland et al. state that their data suggested that heritability may have accounted for at least 80% of the variance, which implies that genetic factors play a major role in liability to anorexia nervosa.

Strober et al. (1990) found that anorexia nervosa was eight times more common in female first-degree relatives of anorexics, than in the general population. They found that about 4% of female relatives (of anorexics) were afflicted in comparison to zero relatives of persons with affective disorder and relatives of a mixed disorder control group. Strober et al. state that there were no cases of eating disorders among male relatives and that the rate for mothers (of anorexics) was three times higher than that for sisters (of anorexics). An analysis of the data suggested a fairly strong familial influence. Strober et al. concluded that families of anorexics appear to have an increased loading for anorexia and that anorexia seems to be familial with inter-generational transmission.

Both Holland et al. (1988) and Strober et al.'s (1990) studies suggest a strong familial influence. Both these studies were based on methods of genetic epidemiology (GE). Methodological considerations of note, in interpreting the findings, are outlined below.

GE studies focus on the inherited/transmitted causes of disease and aim to determine whether the distribution of a particular illness is higher in relatives of afflicted family members (probands) than in the general population or matched control groups (Holland et al., 1988; Strober et al., 1990). The assumption is that a higher distribution in family members of probands implies familial transmission - whether this be genetic or environmental in nature (Strober et al., 1990).

Holland et al. (1988) and Strober et al. (1990) based their studies on the multifactorial threshold model of disease transmission. The latter model assumes that liability (risk) arises from cumulative genetic and/or environmental effects (Strober et al., 1990). High correlations of liability are assumed to imply stronger familiality and correlation of liability values are used to compute heritability estimates (Strober et al., 1990). Strober et al. state that caution needs to be exercised in interpreting heritability estimates, as these are only valid if: (1) there are no environmental causes of resemblance among relatives; (2) genetic heterogeneity is absent; (3) transmission is entirely due to additive genetic factors; and (4) there are no sample biases. Strober et al. state that these conditions were not confirmable at

the time of their study and they could not conclude with certainty, that genetic versus familial environmental factors were operational.

Holland et al. (1988) state that family studies do not distinguish between genetic and environmental transmission. According to Strober et al. (1990) such studies tell us that family factors rather than random factors are influential in the occurrence of a specific disease. Strober et al. point out that heritability is not fixed given that genetic and/or environmental influences can change across time. While such studies may demonstrate familial influences, they do not delineate the exact mechanisms of transmission. Various hypotheses regarding the possible mechanism of familial transmission have been postulated, as follows:

1. Heritable personality traits (linked to phobic and avoidance tendencies) predispose to anorexia nervosa and are accentuated by certain family environments (Crisp, 1995; Strober et al., 1990);

2. Single gene effects which influence behavioural and physical responses to stress; as well as genetic determinants of body composition, weight and weight loss may play a role (Holland et al., 1988; Strober et al., 1990);

3. Inherited vulnerabilities in neurobiological and neurochemical functioning which affect regulation of weight, restoration of weight and eating behaviours may be influential (Bryant-Waugh & Lask, 1995; Holland et al., 1988).

Holland et al. (1988, p. 561) state that "what is inherited, what is learned and what is a response to the environment is complex". Psychological influences within families, such as role-modelling and attitudes to weight/shape may also account for familial transmission. Various authors have commented on the disturbed eating patterns, emphasis on outer appearances and preoccupations with appearance, weight, shape, dieting, food and eating in families with anorexic members (Alessi et al., 1989; Crisp et al., 1980; Jacobs & Isaacs, 1986; Kent et al., 1992; Lieberman, 1995; Minuchin et al., 1975; Schwartz & Barrett,

1987). Alessi et al. (1989) report that in their study, both parents of an anorexic girl had evidenced longstanding preoccupations with weight (food and diet); in addition, the mother had liposuction about one and a half years prior to the onset of the girl's illness. Pipher (1994) cites a case in which the mother encouraged her daughter to diet and started dieting with her. Harper (1983) reports paternal collusion with fathers buying laxatives for their underweight daughters. Hsu (1983) cites a report (by Crisp & Toms) in which the adoptive son of a chronic male anorexic, as well as a girl who was living with the family (as a war refugee) both developed anorexia nervosa. Such reports suggest that powerful family environmental effects may be pivotal in the familial transmission of anorexia nervosa. Hsu (1983) states that adoptive studies are needed in order to elucidate genetic versus environmental effects.

Socio-cultural Factors

Socio-cultural factors considered influential in the manifestation of anorexia nervosa reflect two dominant themes. The first pertains to food abundance *within* social contexts which value and idealise thinness. Ideals of thinness are in turn linked to the second tenet, namely, gender specific constraints and the place of women (and their bodies) within society.

Bountiful Food

Holland et al. (1988) state that dieting is the main reason for weight loss in Western societies. Such weight loss occurs within a global context where in excess of 800 million people are undernourished, starving and hungry, due to food insecurity (Spencer-Jones, 1997). The amelioration of such starvation (occurring mainly in developing nations) is regarded as a global priority by the United Nations, as reflected in the 1996 "Rome Declaration of World Food Security" (aimed at eradicating global hunger and undernutrition) (Spencer Jones, 1997). In contrast, within countries where there is an abundance of food, self-starvation (anorexia nervosa) occurs. Various authors consider anorexia nervosa to be a disease of the affluent (Bruch, 1978; Selvini-Palazzoli, 1985b).

Anorexia nervosa appears to be more prominent in developed cultures and according to the DSM-IV, the disorder is "probably most common" in the U.S.A.; Australia; New Zealand; Japan; Canada; Europe and South Africa (APA, 1994, p. 542). There have, however, been few cross-cultural studies (APA, 1994) and the "sporadic" evidence within developing nations may simply reflect limited research capacity (Szabo et al., 1995). These factors, together with research priorities may have impacted on the global epidemiological profile.

As far as could be ascertained, no epidemiological studies within the South African population, as a whole, have been conducted. There is thus no indication of the particular sectors of the South African population most at risk. Reports (Szabo et al., 1995), however, suggest that the occurrence of AN is not specific to any ethnic group. Within South Africa, the "common" (APA, 1994) occurrence of AN takes places against a background of widespread poverty and unemployment, as well as vast inequities in access to economic (and hence food) resources for the majority of the population. Approximately 20 to 25% of black South African children are under-nourished (Cox, 1998) and in 1995, the Department of Health spent R200 million feeding more than 5 million school children who were targeted according to poverty criteria (Steyn & Labadarios, 1997). Local socio-economic conditions are disparate and research is required to delineate in which specific groups, anorexia nervosa is common. Selvini-Palazzoli (1985a) states that no hospital admissions (to the psychiatric clinic where she was resident) occurred for anorexia nervosa during World War II when food restrictions occurred due to food scarcity. It remains to be seen whether similar findings would emerge in local groups who experience food insecurity due to poverty.

Beautiful Bodies

Thinness is valued, idealised and equated with beauty and worth in many Western societies (Brownell & Rodin, 1994; Bryant-Waugh & Lask, 1995; Garfinkel & Garner, 1984; Speed, 1995). Within traditional African societies, voluptuousness in women was valued and equated with wealth. So too, in the 17th century "soft rounded bodies" were

regarded as attractive (Brownell & Rodin, 1994). Various reports (Hsu, 1983; Kaplan & Sadock, 1989) state that the "ideal" female body, as reflected in Playboy centrefolds and beauty pageant contests, has shown a significant trend towards slimness over the past 20 years. Locally, Szabo (1996) found that the Body Mass Indexes (weight/height ratios) of Playboy centrefolds (S.A. edition) were technically indicative of suboptimal nutritional levels. Szabo, however, queries the incongruities between the visual appearances and stipulated statistics of the centrefolds; the latter disparities raise questions regarding possibly deceptive media influences in relation to the portrayal of the "ideal" female body in terms of weight.

In the U.S.A. the trend towards beauty ideals of slimness has occurred within a context where people have, on average, become heavier (Brownell & Rodin, 1994; Hsu, 1983). Slim beauty ideals have nonetheless fostered an economically prosperous diet industry which in the U.S.A. (in 1994) was valued at more than $30 billion per annum (Brownell & Rodin, 1994; Maine, 1991). In 1994, 24% of American men and 40% of American women were trying to lose weight (Brownell & Rodin, 1994). Locally, certain sectors of the South African population also appear to spend millions of rands eradicating unwanted "fat" ("High cost", 1998).

Globally, there are powerful media influences, including the advertising industry which have significant interests in the diet industry (Brownell & Rodin, 1994). Lasch (1979) argues that the advertising industry has fuelled the obsession with physical appearance. Various authors (Lasch, 1979; Shainess, 1979) have commented upon the narcissistic preoccupations with body appearance and the obsession with food and eating in Western societies. Turner (cited in Halmi, 1995) argues that Western societies embrace ethics of both hedonism and mass consumption, which incipiates a dialectic between self-control and self-indulgence. The latter dialectic manifests in the government of the body through dietary regimens.

Hsu (1983) states that surveys indicate that most young women are dissatisfied with their bodies and want to lose weight. According to Mynors-Wallis (1989) for many years,

16 to 18 year old school girls in the U.K. and U.S.A. have expressed a wish for a precise body weight of 50 kilograms. Social ideals of thinness may foster dieting, which is in itself, a major risk factor for the development of an eating disorder (Bryant-Waugh, 1993a; Halmi, 1995). Women appear vulnerable to conformity to norms regarding thin body ideals; anorexia nervosa is more common in females than males, as well as in dancers, models and gymnasts (APA, 1994; Bryant-Waugh, 1993a; Bryant-Waugh & Lask, 1995; Hsu, 1983; Schwartz & Barrett, 1987).

Schwartz and Barrett (1987) state that many women learn that being attractive, which is equated with being thin, will bring success, intimacy, security and life satisfaction. According to Dittmar and Bates (1987) physical appearance in women has traditionally been linked to status. It has been argued (Brownell & Rodin, 1994) that assumptions which spur the "drive" for a perfect body include the belief that attractiveness is linked to social and psychological rewards, as well as the belief that an imperfect body reflects a lack of self-restraint. Attempts to perfect the body include dieting, as well as surgery. In 1994, liposuction was the most common plastic surgery procedure in the U.S.A. (Brownell & Rodin, 1994).

Constraints (corsets, chastity belts) and mutilation (clitorectomies, foot binding) of the female body have occurred for many centuries with little regard for the associated physical damage (Orbach, 1986). Some of these practices have been directed at attaining beauty ideals. For example, in China for over 1000 years, young girls had their feet broken and bound tightly so that they would remain small (Chinese Historical & Cultural Project, CHCP, 1998; Pang, 1998). The practice was started by a prince in the 10th century, who adored the small feet of his concubine. Small feet were considered beautiful in China and it was considered "impossible" to arrange a marriage for girls with big ugly feet (CHCP, 1998). Footbinding resulted in damaged and deformed feet; the associated pain restricted women's movement and ensured that they did not "wander" (CHCP, 1998). Women from the working classes did not have their feet bound, as they had to be able to work and walk in the fields (CHCP, 1998). It was only in this century, in 1911, that the practice was outlawed (CHCP, 1998). The fable of Cinderella (with her small feet) was first recorded

(in writing) in a 9th century Chinese manuscript (Sierra, 1992). Girls across the globe have for centuries grown up with this fable in which it is implied that being petite is in some way associated with happiness, which is connected to marriage and the love of a "prince". The question arises as to why women conform with beauty ideals which are potentially harmful and damaging? Conformity may have been partially motivated by economic and survival issues since the "beautiful" may have been more likely to acquire a high status marital partner. For some women, marriage may have been a means to securing economic resources, given inequitable access to economic resources due to gender discrimination.

Feminists (Orbach, 1986) argue that seemingly innocuous current thin body ideals (together with methods of attaining these, e.g., severe dieting and liposuction) are no different to past harmful methods of attaining beauty ideals. Orbach (1986, p. 25) argues that such ideals (and methods) are indicative of attempts to control women, and reflect the "rape par excellence" of the female body. Boskind-Lodahl (1981) compares eating disordered women with Cinderella's step-sisters, who try to change their bodies (even if it means cutting off their toes) so that they will fit into the glass slipper which the prince holds.

Ideals of Femininity

Feminists argue that beauty ideals reflect societal power structures (Dittmar & Bates, 1987). The ideal female is portrayed as delicate, in need of protection and childlike in physique (little body fat). Pipher (1994) states that through her body the anorexic girl communicates that she will not take too much (space). Mynors-Wallis (1989) states that the "feminine ideal" prescribes self-denial, as well as deferment to the needs of others. Societal injunctions exist which prescribe that women be self-sacrificing, subjugate their needs to others and take care of others (Mynors-Wallis, 1989; Schwartz & Barrett, 1987). It has been argued (Schwartz & Barret, 1987) that women, within patriarchal societies, have been taught to be passive, dependent, covert and indirect. Schwartz and Barrett state that the injunction has been to create the "illusion" of these attributes, since women were simultaneously expected to actively take care of others. They argue that anorexia nervosa is

congruent with societal prescriptions in that anorexia gives the appearance of inadequacy and dependence. It is, however, also a very indirect method of gaining power and control (Schwartz & Barrett, 1987). Orbach (1986) argues that anorexia nervosa reflects a hunger strike in protest against the social dictates which circumscribe women's lives and relationships.

In conclusion, the main tenet of the socio-cultural hypothesis is that social systems (thin body ideals) contribute to the development of eating disorders. Within many developed nations, there is a preoccupation with dieting; however, dieting (albeit a risk factor) is not the same as the excessive and persistent self-starvation manifested in a very small percentage of the population. Thin body ideals, economic interests (diet industry) and the media may have fuelled an epidemic of dieting but this is not the same as an epidemic of anorexia nervosa.

Eating disorders and disordered eating do, however, have a high profile in the print and visual media (Koz, 1998; Von Geusau, 1998). In addition, high profile women (e.g., Oprah Winfrey, Princess Diana) have confessed (to millions of viewers across the world) their own disordered eating behaviours. It needs to be remembered, however, as Estes (1992) points out, that eating disorders are not the norm for most women and that psychological theory has also contributed to the pathologising of the female body. The DSM-IV criterion of amenorrhea (APA, 1994) implies that anorexia nervosa is a female "disease"; diagnostic criteria which might be used to make a similar diagnosis in self-starving males are not provided. The ICD-10 diagnostic criteria (cited in Kaplan & Sadock, 1998) provide a rather nebulous "equivalent" criterion for men (loss of sexual interest and potency).

Socio-cultural theories highlight the fact that people live in social contexts which may sculpt and influence the expression of psychological symptoms. Anorexic girls may be caricatures of contemporary beauty ideals. However, history (Brumberg, 1988) suggests that fasting girls have existed for centuries and that self-starvation has been used by both women and men (e.g., Ghandi) to attain goals. Thus embarking upon self-starvation may

serve other functions than that of attaining beauty ideals. Nevertheless, narcissistic cultures (Lasch, 1979) preoccupied with thin bodies may play a role in the expression of eating disorders.

Conclusions to Literature Review

A vast amount of literature is available on anorexia nervosa. An attempt has been made within this (limited) review, to highlight the central tenets of physical, psychological, family systems and social theories regarding anorexia nervosa. Research findings suggest that many possible factors may contribute to the emergence of anorexia nervosa and that the aetiology thereof, is multi-determined. Certain common influences with regard to personality factors, family systems and social systems have been delineated. However, it is the view of many clinicians and researchers within the field, that the exact aetiological processes or optimal treatments remain controversial, despite the multitude of research (Bryant-Waugh & Lask, 1995; Gowers et al., 1991). Given the apparent multi-determined nature of the illness, various authors (Bryant-Waugh & Lask, 1995; Garfinkel & Garner, 1982; Wren & Lask, 1993) state that it is helpful to conceptualise the illness in terms of predisposing, precipitating and perpetuating factors. Predisposing factors would include the contexts (e.g., social ideals of thinness; family systems; family psychiatric history), as well as individual factors (e.g., personality and cognitive factors; ego deficits; maturation fears; genetic factors) which lay the ground for the potential emergence of the disorder (Bryant-Waugh & Lask, 1995; Garfinkel & Garner, 1982). Precipitating factors would include the "triggers" (e.g., puberty; separation; family tensions) which initiate the illness within the context of predisposing factors (Bryant-Waugh & Lask, 1995; Garfinkel & Garner, 1982). Perpetuating factors would include events and situations which maintain the illness. For example, the secondary gains of starvation (e.g., interpersonal); the physical sequelae of starvation (e.g., increased preoccupation with food; decreased self-esteem due to impaired cognitive and interpersonal functioning); cultural ideals of thinness; and iatrogenic factors (Bryant-Waugh & Lask, 1995; Garfinkel & Garner, 1982). Such a multi-dimensional conceptualisation would facilitate a cybernetic approach, in which the patterns and connections between the predisposing, precipitating and perpetuating factors could be taken

into account. A multi-dimensional conceptualisation of anorexia nervosa implies a multi-dimensional approach to treatment. Various authors (Gilchrist et al., 1986; Hall, 1987; Lockwood, 1986) state that treatment approaches should maintain a balance between the different systems, as opposed to relying exclusively on one approach only (e.g., family therapy or individual therapy). Vandereycken (1987) states that since the 1970's, clinicians have favoured an eclectic approach, combining individual (psychodynamic; behavioural) and family (structural and strategic) approaches. Despite the multi-determined nature of the illness, as well as the need for an eclectic approach, Vandereycken (1987, p. 460), cautions against "supermarket" treatment approaches "in which an accidental accumulation of techniques is used as a machine-gun to ensure that at least some targets are hit".

In conclusion, conceptual and treatment approaches should take into account the specific factors which appear to be pivotal in the onset and maintenance of each individual patient's illness. With regard to the current "state of knowledge" regarding anorexia nervosa, a vast amount of theoretical and clinical knowledge has been accumulated regarding potential aetiological factors. Further empirical research is, however, needed regarding the efficacy of different treatment approaches. In addition, more epidemiological studies are needed to clarify claims that an "epidemic" of eating disorders has occurred over the last few decades. Such knowledge would have implications for the design of interventions at a public health level, in terms of addressing social factors (e.g., media influences; diet industry) which contribute to the production of predominantly gender-specific psychological disorders, such as anorexia nervosa.

CHAPTER 3

CASE PRESENTATIONS

Gabrielle's peaches

Once there was and once there was not[1] a little girl, Gabrielle, who lived in a faraway curious place on the strange side of the world. In this land, the sun did not object to the rain falling while the sun was brightly shining, or maybe it was that the rain did not object to the sun shining while it was softly raining. Nonetheless, the shining sun and falling rain worked together, touching the buds upon the trees so that one day they might - or might not - become something other than a little green bud. There were many trees on the strange side of the world. Some were big and tall (like giants) and filled with peaches. Others were small (like dwarfs) and were covered in colourful buds and blossoms, waiting to grow.

In the shadows of the trees, Gabrielle was gathering some succulent yellow peaches which had fallen to the ground. As she picked up each peach, she wiped away the soft down which enveloped it and put it into her basket. Not far from her, her mother Olivia, father Julio and brother Vincent, sat talking loudly about the peaches which lay scattered about them. It sounded like they were disagreeing about the art of peach eating. It was difficult for Julio and Olivia to agree about most things but they had agreed many summers ago, to ask the wind to carry them across the sea to this faraway place. The wind - an amiable being - had conceded to their request and so Julio and Olivia had set about building themselves a boat. One day,

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1. Estes (1992) states that this age-old paradoxical way of beginning a story is intended to alert listeners to the "fact" that the story takes place in a world between worlds, where things are not as they seem at first. In this narrative, the paradox is intended to alert the reader that the factual case history has been woven into the narrative. The presentation of the case in this manner is intended to protect the anonymity of the patient, as well as to integrate the case presentation with the second half of the narrative which is a verbatim oral account by the patient of the story of her illness and treatment. Identifying details have been changed to protect the anonymity of the patient. Issues pertaining to the latter will be discussed at the end of this section.

while they stood upon their boat disagreeing about what size the boat should be, the wind rushed up across the sea, creating big waves and wobbling the boat up and down upon the water. The wind had become impatient to travel to the other side of the world and was tired of waiting for them to agree about how big or small their boat should be. So, it blew them and their boat all the way across the world until they landed with a bump on the strange side of the world. Julio and Olivia's journey had been very wobbly and as could be expected, they had spent the journey discussing who was to blame for the wobbly boat. Nonetheless, when their boat bumped the other side of the world, they decided to step off the boat onto the soft sand. They looked up at the many trees and decided that the next day they would build themselves a house.

A few summers later, Vincent was born and three summers after that Gabrielle was born. Gabrielle was special to her mother and in many ways, Olivia and Gabrielle believed that they were one and the same person. They could understand and see things that Julio and Vincent could not see, like the little monsters who lived in the shadows of the peaches. The monsters were hungry little people who wanted all the peaches for themselves. They spent most of their days and nights eating the peaches until their tummies were so big and full that their legs could no longer hold them up. Whenever anybody ventured near the peaches, the monsters would try to frighten them away by telling them they would become big and fat if they ate the peaches. Olivia could hear the monsters, and Gabrielle being in some ways like her mother, also came to hear and fear the monsters. Like her mother, she became frightened of the peaches and so she found it more and more difficult to eat until one day she was like a shadow of the girl she might have become. Over the past summer, Gabrielle had become curious about the peaches which lay in the shadows of the trees. It seemed as though she was a little less frightened of the peaches and as though she had a tale to tell about this curious place. The wind, the rain, the sun and the trees noticed her softly calling for their attention and they stopped talking amongst themselves so that they could hear what she had to say. Her family could still be heard in the distance - debating the art of peach eating - but even the small monsters emerged from the shadows of the peaches to listen to Gabrielle. Gabrielle was lively as she told her tale and every now and again, she would bend down to draw a picture in the soft sand.

Gabrielle said[2] *there was a family with four people - a mother, a daughter, a father and a son. The daughter thought that she was a very fat girl - like her father - and (she thought) the mother was very thin and her brother a lot thinner than her, but in real life she wasn't fat. She thought that she was so fat that a monster[3] called "Mash" came to visit her and he always told her "you must exercise, you are fat, eat what Vincent eats, don't change". She was so scared and so sad and cross (that she listened to Mash) but she did it anyway because he told her to. So she stopped eating and she got thinner and thinner and thinner.*

Then her mother brought her into the hospital and they helped her to shrink Mash - by making her eat, do therapy, do groups, occupational therapy. Mash was getting smaller and smaller every day. She started saying "no" to him and day by day she was getting better and imagining herself one day to be a beautiful young lady and every day she was imagining herself to get prettier and prettier and taller and taller.

The more therapy she did, she found that her mother also had a monster. He was big, big and fat. His name was Bruno and that made her (mother) the same as Gabrielle - scared, sad and cross. Bruno said that she must get thinner and exercise and blah, blah, blah - also, Bruno and Mash were so mean and ugly because they came from hell.

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2. The entire story from this point on, is the patient's verbatim orally narrated account of her illness and treatment. The narrative was based upon the drawings she created in therapy , two of which are included amidst the tale. Due to the fact that it was an oral narration spoken with reference to each of her drawings, the story may at times appear disjointed. Nevertheless, the original version has been retained.

3. The idea of the "food monster" was introduced into the therapy based on Michael White's (1989) technique of externalising the problem.

Figure 1. Gabrielle's drawing of Mash shrinking.

Figure 2. Gabrielle's drawing of "Fat Bruno" - her mother's monster.

One day, the situation with Bruno and Mash was so harsh - between (them and) Vincent, Olivia and Gabrielle. Bruno called it "Bruno's race". He wanted them all to get thin and eat less, and then they would get a trophy. And because Gabrielle turned 13, she got an angel, Sabina[4], who flew above her. Sabina was wonderful and loving and with Gabrielle all the time. Anyway, they had a big conversation between Bruno, Mash, Sabina, Olivia, Vincent and Gabrielle. Mash said to Gabrielle "you are eating too much or Vincent is eating too little". Bruno said to Gabrielle "you must be the thinnest". Sabina said to Bruno and Mash "leave Gabrielle alone!" Gabrielle said "I want to be thinner than everybody in my family specially Vincent". Sabina asked "why?" and Gabrielle said "because I am younger and smaller". Sabina asked her "do you want to stay young and small?". Gabrielle said "no - but why does Vincent not eat more than me?". Sabina asked Gabrielle "are you worried that you will grow and Vincent won't grow?". Gabrielle said "no - but I'm scared I will grow big and fat and he will stay tall and thin". Sabina asked "are you in a competition with Oscar?" and Gabrielle said "I don't know?". This is how Bruno's race went: at the moment, Vincent is thinnest - so he got a trophy from Bruno - the trophy said "you are the winner and now you will get more attention from all of us and your family, specially your mother". So Gabrielle said (because she wanted to be the thinnest) "I feel left out, lonely and sad because Vincent is thinner and is getting more attention". Mash was teasing her "Gabrielle, you are fat!". Gabrielle was very upset, crying and crying and saying "go away" and because Gabrielle was upset, so is Sabina and she (Sabina) is having the same tear as Gabrielle. And this conversation was going on with all of them except Gabrielle's father, Julio, and he says loudly "I feel sad and left out because Bruno and Mash have taken over my family."

A few weeks later when Bruno and Mash were starting to get smaller and smaller, the family was sitting at the table and before them was a delicious meal. Next to the dinner table, Bruno and Mash were standing. Bruno says "carry on the race, carry on the race, carry on the race, carry on the race, carry on the race" and at the same time but not at the dinner

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4. The idea of the "angel" was introduced into the therapy in order to invite the patient into conversation with a "good internal object", which could challenge the dominant negative internal/external conversations (story) about puberty. This introduction occurred during a therapy session when the patient appeared to be particularly saturated in her dominant negative "stories" about puberty.

table, when Gabrielle is bored and does not know what to do, Mash says "think you are fat, think you are fat".

So, Bruno and Mash were getting smaller and smaller. Sabina was getting bigger and bigger in her (Gabrielle's) heart and she (Sabina) had a medal that said "Gabrielle: happy life, love and care, friends and family, for beating Bruno and Mash". Sabina gave this medal to Gabrielle because she did so well in her last four months at the hospital. That (the medal) she was holding in her one wing, in the other wing she was holding a big blue and pink present. And in the present for Gabrielle, it was from Mother Teresa - no - Mother Nature. Inside the present was "puberty" - breasts; period; hips; nice figure with shape; nice long hair; babies; wonderful life; going out; having fun; having children; be a nice mother; do what you want to - like swim.

The End!

And then Gabrielle left the hospital and was a healthy, happy, wonderful girl".

As Gabrielle finished telling her tale, there was some movement in the shadows of the trees. A little girl, Sandy, had been listening to Gabrielle's story. She was sad because the monsters had played the same game with her and her mother. They used to frighten her by telling her that her cheeks were fat and that if she ate, she would get bigger and bigger. Like Gabrielle's mother, Sandy's mother was also frightened by the monsters - so, she started eating less and less. It was not long after that, that Sandy also began to eat less and less. Soon she was a shadow of the girl she could have been. Like Gabrielle, Sandy came to the hospital to try to fight the monsters which had frightened her into eating less and less.

Case Discussion

On eating less and less

Gabrielle and Sandy were two consecutive referrals of early onset anorexia nervosa (restricting sub-type) to an inpatient eating disorders unit in a psychiatric hospital, during a six month period. Both girls originated from intact upper-middle class professional families and were above average scholars. They were both 12 years old when they presented for inpatient treatment of anorexia nervosa, however, the onset of symptoms had occurred earlier. About one year earlier, at the age of eleven and a half years, both girls had experienced a growth spurt in height which had aroused anticipatory anxieties regarding puberty. Shortly after each girl evidenced her growth spurt in height, her mother embarked upon a weight reduction programme. Both mothers had lost a significant amount of weight (about 10 kilograms) and were thin upon their daughter's admission to hospital. The mother's weight loss had been rapid and both had been surprised by how quickly they had shed their own weight. Both mothers perceived themselves to have been fat prior to dieting, however, this was not the perception of family members.

In-depth assessments of maternal attitudes towards their own weight and eating were not taken, however, in the one case, this was volunteered by the mother. Based on the latter, the mother herself appeared eating disordered as evidenced by her preoccupation with weight; the extreme influence of her body weight on self-esteem; and her fear of fatness and drive for thinness (e.g., excessive exercising and food restriction). It was the opinion of her husband that she was herself anorexic. While she had throughout her life evidenced concerns about her weight, as well as poor self-esteem associated with her body shape, the overt behaviours aimed at weight reduction had mainly become apparent at the time when she embarked on the above-mentioned weight reduction programme. She stated that her recent weight reduction programme had been aimed at thwarting anticipated changes in body size and shape, associated with developmental hormonal changes.

The onset of dieting in the two girls followed shortly after each girl's mother began to diet. Both girls had reduced and restricted their food intake, as well as exercised in an attempt to lose weight. They both evidenced a fear of fatness and distorted body image on admission. Gabrielle and Sandy were both premenarcheal, although their recent growth in height suggested that they had entered the beginning stages of puberty. On admission, Gabrielle weighed 27 kilograms and a target weight was set at 36 kilograms. Sandy weighed 32 kilograms on admission and her minimum target weight was set at 40 kilograms. Target weights were calculated according to population norms for age and height, although these were adjusted downwards by about 10% to provide a minimum target weight for discharge. At the time of admission, both girls were significantly underweight and had lost about 20 to 25% of their previous body weight prior to the onset of anorexic symptoms. One of the girls was slightly underweight prior to the onset of symptoms. In both cases, weight loss was rapid following the onset of symptoms. This is in accordance with other reports (Irwin, 1984) which indicate that children deteriorate more rapidly, given less initial body fat.

Systemic Patterns

The history of the illness, as provided by the patients and their families, suggested a tendency towards interactional symmetrical (competitive) processes in the mother-daughter relationship, as reflected in the sequential nature of the mother-daughter dieting. The question arises as to whether such processes were connected to the initiation and escalation of weight loss. These processes will be discussed below with a view to providing a process-oriented description of precipitating factors associated with symptom onset and maintenance. From a systemic point of view, these processes will be considered in terms of the structural and cybernetic aspects of family functioning. Alternative theoretical interpretations will also be considered.

Symmetrical Processes

It has been suggested above that the sequential nature of the mother-daughter dieting described in the two cases, reflected a symmetrical dance within this relationship. This

interpretation is based upon Batesonian theory and will be expanded upon, following the brief theoretical synopsis of Batesonian theory provided below.

Bateson's theory of communication (which was based on Bertrand Russel's theory of logical types) dealt with the process of the classification of messages (Bateson, 1979; Bateson, Jackson, Haley, & Weakland, 1956; Grinder & Bandler, 1976). Bateson et al. (1956) classified (categorised) two levels of messages in communication: verbal and non-verbal. This classification emphasised that context (e.g., non-verbal behaviour) is important in understanding interactions. Bateson (1979) named two categories of interaction, namely complementary interactions and symmetrical interactions. Categories of interactions represent a kind of choreography for the participants in the relationship (Keeney, 1983). Bateson postulated that descriptions of the choreography of interactions are of a higher logical type than simple descriptions of behaviour (e.g., dieting). Describing interactions entails identifying how interactional patterns (complementary and symmetrical) are patterned, connected and sequenced (Keeney, 1983). Behaviour is thus defined as complementary or symmetrical based on the connecting behaviours which precede or follow it (Keeney, 1983). Complementary interactions would be those characterised by a mutual fit, for example, dominance-submission; dependence-nurturance; "one-up" and "one-down" interactions (Keeney, 1983; Raymond, Friedlander, Heatherington, Ellis, & Sargent, 1993). Symmetrical relationships would, for example, be interactions characterised by competition, rivalry, struggles for control, and mutual emulation (Keeney, 1983; Raymond et al., 1993). According to Bateson (1979) either of these two patterns (complementarity and symmetry) can potentially lead to schismogenesis (an escalating pattern leading to intolerable stress and dissolution of the relationship). Schismogenesis results from the progressive change (escalation) inherent in cumulative symmetrical or complementary interactions (Watzlawick, Beavin, & Jackson, 1967).

Systemic psychological theories and approaches based on Bateson's theory emphasise the context in which "simple" behaviours (e.g., not eating or eating very little) take place. In addition, such approaches focus on the description of interactions and the recursive nature of interactions (Keeney, 1983). The focus is on discerning patterns of interaction, as well as the connection between the actions between the participants (Keeney, 1983). With reference to the

two cases described above, the sequential processes surrounding the onset of illness, appeared to reflect a competitive (symmetrical) relationship in which the behaviour of the mother (dieting) was followed by a symmetrical response from the daughter (dieting). In turn, the sequential events which preceded this symmetrical interaction appeared to be the changes associated with impending puberty, as reflected in the two girls' growth spurt in height. The "meaning" of puberty and the changes associated therewith, for the two girls and their families, will be discussed below, following which the connection thereof to the onset of illness, will be considered with reference to the aforementioned sequential processes.

On Growing Up

Gabrielle was quite candid about the fact that she did not want periods which for her, implied restrictions and the loss of her girlhood bodily freedoms. She admitted that her food restriction had partially been an attempt to stave off physical maturation as she "knew" that if she wanted to grow, she had to eat. Sandy too had been anxious about the expected bodily changes associated with puberty, such as the development of her breasts. Thus, maturation fears, following signs of early puberty (growth in height) were evident in both cases. While some of these anxieties pertained to bodily changes, they also included anticipated changes in family relationships. One girl stated that growing up meant "being alone" and "going away from your family". This, she said, would make her sad.

Numerous authors (Bruch, 1978; Evans & Street, 1995) have commented upon the maturation fears evidenced in patients with anorexia nervosa. Stierlin and Weber (1989) found that attempts to avoid growing up were inter alia, one of the precipitating factors in the onset of symptoms. In terms of the anxieties regarding bodily changes, literary reports (De Beauvoir, 1952; Deutsch, 1944) suggest that anxieties in young premenarcheal girls regarding menstruation, are not uncommon. Attitudes to menstruation appear to be influenced by maternal attitudes (Deutsch, 1944; Shapiro, 1988) and in the above-mentioned case, the girl appeared to have internalised her mother's expressed negative experiences of, and attitudes towards, menstruation. In addition, in the latter case, parallel processes were evidenced between mother and daughter with regard to their attempts to thwart anticipated physical

developmental changes (menarche and menopause) in body size and shape, through weight reduction.

From an individual point of view, the onset of illness could be viewed as connected to the girl's pubertal anxieties. However, if the relational sequencing of events is taken into account, the pattern is as follows: growth height, maternal dieting, daughter's dieting. The question thus arises as to whether the "growing up" of the girls precipitated maternal anxieties and/or shared mother-daughter anxieties around maturation. Within both families, anxieties were expressed regarding the "separations" associated with maturation. Developmental changes and the anticipated individuation associated with adolescence were confused with the end of relationships. Within the one family, these anxieties appeared to be multi-generational in origin (the parents evidenced unresolved conflicts regarding separation from their families of origin). In this family, a number of separations associated with lifestyle changes had occurred prior to the onset of symptoms.

In terms of the separation associated with hospitalisation, both families experienced difficulties therewith. Distress was evidenced by both girls about being away from their families and one girl threatened (her parents) that she would abscond or commit suicide if she was not removed from hospital. The latter appeared to be associated in part, with fears of becoming fat in hospital. Again, this is not unusual as resistance to treatment is common in anorexia nervosa (Kaplan & Sadock, 1998). Magagna (1993) states that suicidal threats are common in anorexic children when they feel that their omnipotence is being challenged. Snyders (personal communication, May 21, 1998) suggests that anorexia could in itself be viewed as a "chronic suicide posture...she walks perilously close to the edge - she knows that she will not fall but those around her are not certain. This is power and control. The cybernetics of risk which ensure that she remains in control". The aforementioned suicide threats may have been related to the loss of control associated with hospitalisation.

In terms of the broader anxieties regarding separation, various authors (Becker et al., 1981; Bruch, 1978; Evans & Street, 1995; Farrell, 1995; Plaut & Hutchinson, 1986) have commented upon the difficulties experienced by anorexic patients regarding autonomy and

individuation. Stierlin and Weber (1989) found that actual or feared separations were one of the precipitating factors associated with symptom onset.

In addition to the abovementioned (familial and individual) anxieties about psychological maturation (separation associated with adolescence), both girls evidenced anxieties regarding physical maturation (bodily changes). The question thus arose as to whether the onset of dieting was an attempted systemic solution to the problem of "growing up". In other words whether the mothers (non-verbally) presented a solution (dieting) to the problem (changing body/shape and size) associated with maturation. In the one mother-daughter dyad, the daughter's anxieties regarding menarche were connected to her mother's accounts of her own menstrual history. Both mother and daughter anticipated that the experience of the daughter (menstruation, pregnancy, body image etc.) would be exactly the same as that of her mother. The mother did not want her daughter to experience the same pain in relation to these issues and stated that she would prefer her daughter to remain on the "thin side". Thus it is possible that her dieting may have been a non-verbal offering to her daughter of a "way out" of what lay ahead. Alternatively, the girls (in both cases) may have observed their mother's dieting and decided (independently) that this was a good solution to the problem of the anticipated changes in their own body shape and size.

The rapid sequencing of events in terms of the pubertal height spurt and mother-daughter dieting suggested some connection between the two events. The question arose as to whether the physical maturation of the girls threatened the previous status quo in the mother-daughter (complementary parent-child) relationship. In other words, the maturation may have been interpreted as a symmetrical message (competitive challenge) within the relationship. The latter may have precipitated a symmetrical interaction, as reflected in the pattern of mother-daughter dieting. Snyders (personal communication, May 21, 1998) suggests that the cybernetics of symmetrical interactions in relation to anorexia nervosa, may be that "one person starts the process, the other competes...the first one thinks that control means going one step further, the second one responds by thinking `I am still in control of my life, I can risk eating less to control the other' ".

The symmetrical nature of the abovementioned mother-daughter interactions (dieting) appeared to provoke other symmetrical cycles, associated with blame/guilt, in the families. Within both families the mothers, in particular, blamed themselves for their daughter's illness. Maternal guilt was expressed mainly in relation to having dieted but also for not "knowing" or recognising the early symptoms of anorexia nervosa (initially not taking the symptoms seriously). Within one family, both parents felt extremely anguished by the possibility that they may have "caused" their daughter's illness through their "overprotectiveness". Literary reports (White, 1989) indicate that parental guilt is common in families with an anorexic member. White (1983, p. 261) states that "popular, sexist...notions of...mothers as the 'root cause' of anorexia nervosa" contribute to the cycles of guilt and blame within families. According to feminist authors (Sayers, 1988; White, 1989) psychological theories have blamed mothers for most psychological illnesses, thereby inducing maternal guilt and heightening the distress associated with the illness of a child. In addition, mothers are largely accorded responsibility for food within families and this may also contribute to maternal guilt.

Systemic theorists (Bateson, 1972; White, 1989) argue that psychological explanations which attribute direct responsibility to one person for the illness of another, are fundamentally arrogant since they assume that one person has complete power over another. White has commented upon the redundant guilt/blame cycles within families with an anorexic member. Selvini-Palazzoli (1985b) also observed that blame-shifting was part of the interactional dysfunction within such families. Within one of the families under discussion, blame-shifting occurred within the parental dyad regarding the origin of the daughter's illness. The blame-shifting appeared to reflect symmetrical processes within the parental relationship which went beyond the "content" of "who was to blame" for the anorexia. There appeared to be a general tendency towards symmetrical interactions within this relationship which heightened conflict and provoked threats regarding the dissolution of the marriage (i.e., there were processes leading to potential schismogenesis). Although conflict had been present throughout the marriage, this had heightened over the past two years following major lifestyle changes. The question arose as to whether the girl's symptoms had been an attempt to halt "runaway" change associated with both developmental and economic changes within the family system. The daughter's illness appeared to have taken on a function within the family system, given that

the parents were able to unite in their "love" and concern for their daughter, thereby creating temporary "truces" within their relationship. Reframing the daughter's symptoms through positive connotation appeared to "block" some of the symmetry in relation to the parental blame-shifting (her illness was connoted as halting parental fighting; restoring family tranquillity; and providing some kind of stability for the parents).

The preceding discussion has highlighted the sequencing of events immediately prior to the onset of symptoms. In addition, some of the symmetrical processes common to both families have been discussed - with the exception of "Bruno's race". Gabrielle, in her narrative, raised the issue of competitive relationships within the family regarding food intake. Within her family, a number of parental relational struggles pertaining to families of origin, were acted out around food. However, it was not clear whether Gabrielle's concern regarding what other family members were eating was reflective of a symmetrical interactional process *within* the family system, or not. The expressed concerns may have been part of the individual anorexic symptomatology (starvation) given that it has been noted that anorexic patients display preoccupations with the food intake of others (Kaplan & Sadock, 1998). However, such preoccupations could in themselves reflect symmetrical/competitive processes associated with the illness. The latter, together with the overall symmetrical tendencies evidenced in the two cases, will be considered in conclusion to the case studies, with reference to the choreography of anorexia nervosa. Prior to this, the structural aspects of family functioning will be briefly mentioned.

Symbiosis/Enmeshed Identities

From a structural point of view, difficulties acknowledging the separateness and autonomy of family members were evident in both families and appeared to be expressed around the control of body function (eating; activity levels) or physical appearance (clothing, hairstyles etc). Enmeshment within the families was evident, as reflected in communication processes - speaking for one another; sharing the same answers, thoughts and feelings; as well as in the lack of differentiated senses of self. The latter was particularly evident within the mother-daughter dyad in terms of over-identification and what appeared to be an exchangeable

sense of self. In terms of these processes, it is possible that the girl's dieting, following that of the mother, may have reflected an over-identification and inability to maintain a separate identity (differentiated sense of self). This process could have been part of the interactional process and/or part of the individual make-up of mother or daughter. In other words, the mother may have acted upon her daughter's anxieties about changing body shape and size, or the daughter could have acted on her mother's concerns about weight. Either of these processes could have reflected the internalisation/incorporation of the anxieties of the other, which were then acted out.

Various authors have commented upon the enmeshment within *some* families with an anorexic member. Norris (1979, p. 991) states that a "strange entanglement often exists between an anorexic girl and one of her parents, usually the mother" such that "neither appears to have a separate emotional existence". Norris found that this interactional pattern was observed in most of the families in his study.

With reference to the two case studies, other structural aspects of family functioning of note, included inappropriate boundaries as evidenced in cross-generational (parent-child) alliances, as well as poor sub-system boundaries. Triangulation of the children in parental conflict was apparent in the one family. These aforementioned aspects of family functioning confirmed the findings of others (Minuchin et al., 1975; Minuchin, Rosman, & Baker, 1978) regarding enmeshment, overprotectiveness, triangulation and cross-generational alliances.

Summary

The above case presentations have highlighted the symmetrical tendencies apparent in the family systems of two patients who presented for treatment of early onset anorexia nervosa. The main focus of the discussion has been on the sequence of events prior to the onset of symptoms. The sequencing (girl's height spurt - maternal dieting - daughter's dieting) was common to both cases and appeared connected to the emergence of anorexic symptoms. It has been suggested that the girl's dieting, following that of her mother, was reflective of two systemic processes. Firstly, an exchangeable sense of self, associated with enmeshment and

the lack of differentiation within the mother-daughter dyad. Secondly, a symmetrical interactional process within the mother-daughter dyad. The latter will be considered below in terms of the choreography of anorexia nervosa.

Choreography of Anorexia Nervosa

It has been suggested in the discussion of the case studies, that the choreography of the relationships in the mother-daughter dyads, was reflective of a symmetrical dance. Various authors have commented upon the "competitiveness" associated with anorexia nervosa. Selvini-Palazzoli (1985b), for example, commented upon the competitiveness (which manifests in escalating symmetrical processes within the parental relationship) regarding whom has been the greater martyr in the marriage. Schwartz and Barrett (1987) noted competitive struggles for the approval of the father. Norris (1979) commented upon the competitive striving evidenced by many anorexics. Escalating symmetrical processes in relation to the control of food within families with an anorexic member, have also been noted (Raymond et al., 1993; Selvini-Palazzoli, 1985b). Bruch (1988) suggests that anorexia has over the last few decades become a fashionable illness, which girls may be competitive about. The observed interactional processes evidenced in relation to the onset of illness in the two case studies, also suggested a symmetrical component to the illness. This interpretation supports the findings of others (mentioned above) in terms of the symmetrical/competitive aspects of anorexia nervosa. However, in addition to commenting upon the symmetrical aspects (the mother-daughter dieting) evidenced in the family relationships, it was also suggested that these symmetrical tendencies and processes may have precipitated the illness. This perspective will be expanded upon below in terms of the overall processes inherent in anorexia nervosa.

The symptoms of anorexia nervosa, in terms of the escalating weight loss suggest that at a process level, the illness reflects a symmetrical dance with the world. This world may include the internal world of the anorexic (e.g., traits of perfectionism), as well as the relational world of the anorexic (e.g., competitive processes within the family) and the wider global world (e.g., thin body ideals; media influences which entice women to strive towards the perfect/thin body). The symmetrical dance of the anorexic may reflect an attempt to master

a world which increasingly sets her off balance (e.g., through developmental changes; poor self-esteem). Her symmetrical relationships with the world come to be danced upon the stage of her body. A number of factors may propel her towards the choice of her body as the stage for her symmetrical dance. For example, Bruch (1978) suggests that early relational experiences in relation to the body predispose towards anorexia. In addition, social ideals of thinness may direct the anorexic towards acting out her symmetrical tendencies upon her body. Also, family systems may play a role given that research suggests that families of anorexics are overly preoccupied with appearance, weight, shape, dieting, food and eating (Alessi et al., 1989; Crisp et al., 1980; Jacobs & Isaacs, 1986; Kent et al., 1992; Lieberman, 1995; Minuchin et al., 1975; Schwartz & Barrett, 1987). These contextual factors may thus provide the "content" (food and the body) to which the symmetrical interactional *processes* become attached (Snyders, personal communication, April 28, 1998). Snyders (personal communication, June 3, 1998) states that food also may become a "metaphorical answer to relational hunger in the face of tenuous connections or varying coalitions; relational starvation may thus come to be played out as somatic starvation".

Viewing anorexia nervosa in terms of the choreography or "dance" of the illness, implies that psychological interventions should be directed, inter alia, towards the symmetrical processes which contribute to (and maintain) the illness. Such interventions could include the introduction of "complementary" processes into the anorexic's relationships. Structural approaches, for example, increase the complementarity of relationships through the definition of sub-system boundaries (Raymond et al., 1993). The effectiveness of such approaches (Minuchin et al., 1975, 1978) with young anorexics, as well as the efficacy of the family counselling model (Dare et al., 1995) may partially be related to the blocking of escalating symmetrical tendencies (acted out around food) through the introduction of complementary processes (i.e., through the definition of complementary sub-system boundaries - e.g., parent-child). Similarly, inpatient nursing interventions also define the relationship between the nurse and anorexic as "complementary" (patient-therapist) in relation to food intake. This definition (if accepted) may in itself be fundamental in halting the symmetry associated with the illness. Difficulties may, however, arise with the acceptance of the definition of the relationship as complementary, particularly with anorexic adolescents, given the developmental issues around

separation and autonomy. However, interventions can successfully address this problem while still incorporating the restructuring of relationships (Dare et al., 1995). Aside from the aforementioned treatment modalities, other interventions targeted at the symmetrical processes, could include the positive connotation of symptoms (as discussed in the case presentation) which may facilitate a decrease in symmetrical processes (e.g., blame-shifting). Finally, interventions could be guided by the notion of "positive deviance" - in other words, the tendency towards "symmetry" could be put to better use by finding more "appropriate" and less destructive "objects" in relation to which the symmetry could be displayed (Snyders, personal communication, April, 1998).

A focus upon the choreography of the illness, in essence, implies that second-order interventions need to occur. In other words, the focus needs to be upon the patterns and recursive processes maintaining the illness. Such an approach is consistent with a cybernetic approach to therapy which entails focusing on recursive processes and patterns (Keeney, 1983). Systemic approaches are, however, not without their problems. The advantages and disadvantages of a systemic approach to the case material, will be delineated below.

One of the major emphases in systemic explanations is upon the context within which behaviours occur. Systemic theorists (Auerswald, 1990) have criticised psychological theories which focus upon the individual's "pathology" without reference to the context in which such pathology occurs. Systemic approaches focus upon patterns and sequences surrounding dysfunctional behaviours. One of the advantages of this focus is that the shift to pattern enables a move away from linear cause-effect notions of illness. Such notions have a tendency to confuse aetiological processes with "blame" and to locate "blame" in individuals (the mother, the patient etc). Although systemic approaches have attempted to move away from such explanations, such approaches have frequently (in practice) implied that families "cause" illness. Within the case studies presented above (and the systemic interpretation thereof) the intention has not been to imply that the mother - through her dieting - "caused" the daughter's dieting (which culminated in anorexia nervosa). The intention has rather been to suggest that the sequential nature of these events, reflected a symmetrical process within the choreography of the mother-daughter relationship, which facilitated the emergence of symptoms. Both

mother and daughter were part of this interactional sequence.

It is, nevertheless, tempting to try to trace the origins of the symmetry within this relationship. In other words, was the symmetry a response to impending puberty, or were these girls born into family systems with tendencies towards symmetry? Both interpretations appear to be plausible explanations of the symmetry within the mother-daughter dyad. However, attempts to trace the "origins" of symmetry moves the focus from the choreography of the relationship (pattern), to actual events (in time), which can "slip over" into a tendency to blame. As mentioned previously, families with an anorexic member have been found (Selvini-Palazzoli, 1985b; White, 1989) to display patterns of blame-shifting and guilt/blame cycles. Psychological explanations thus need to take care not to collude with these processes. In addition, there are multiple factors which appear connected to anorexia nervosa, which extend beyond the context of the family to the wider social context.

One of the difficulties with a systemic approach, specifically in relation to tracing sequential events, is that the search for sequential events and patterns, in itself, has a tendency towards infinite regression. Thus, the observer gets caught up in a symmetrical process pertaining to the observed. For example, the initial sequencing "unit" was the mother-daughter dieting. However, prior to the maternal dieting, the two girls had experienced a growth spurt in height. Prior to this, there had been numerous other apparently connected sequential events which may have been associated with the eventual emergence of the illness. For example, family life style changes; peer relationship difficulties; and early developmental histories (e.g., feeding difficulties). Tracing the sequence of connections even further back, other systemic events prior to the birth of the patients (e.g., conception difficulties; "precious" babies; multi-generational issues around feeding; marital system difficulties associated with families of origin) may have been connected sequentially (albeit more distantly) to the eventual emergence of symptoms. It is thus difficult to track the sequence and impact of all the events which may have contributed to the eventual emergence of symptoms. A focus upon the choreography of the interaction, albeit limited, provides a way out of the infinite regression inherent in the search for sequential events and the origins of interactional patterns. However, one of the limitations of a focus upon choreography is that the significance of critical events (e.g.,

puberty, genetics, temperament, individual behavioural and dynamic factors) is overlooked. As outlined in the literary review, research suggests that such factors are implicated in anorexia nervosa.

Finally, one of the major difficulties with maintaining a systemic approach is that it becomes difficult to conceptualise in a coherent and integrated manner, the multiple connections between the multiple contexts (e.g., individual, family, social) implicated in anorexia nervosa. Although, a systemic perspective is emancipatory in terms of shifting the focus from a narrow perspective on single systems to a more inclusive focus on multiple connections between multiple systems, such an approach, as outlined above, presents difficulties of its own.

So once there was and once there was not...

At the beginning of the narrative, the issue around connections and the interpretation thereof, was raised in relation to the role of the sun and the wind in the curious place, on the strange side of the world, in which Gabrielle lived. Within the discussion of the case study, the focus upon symmetry has been one of many possible interpretations of the mother-daughter dieting (which appeared to be a critical factor in the onset of symptoms). For example, from a behavioural point of view, the daughter's dieting could have been interpreted as role-modelling (of her mother) or a learnt response. From a psychodynamic point of view, the apparent competitiveness at the time of puberty, could have reflected the re-emergence of earlier unresolved issues/fixations in relation to the oedipal complex. Similarly, the apparent lack of differentiation could have reflected incomplete psychological development which could have been traced back to early infancy/childhood.

One of the advantages of a focus upon the choreography of the illness, is that such a perspective goes beyond the abovementioned theoretical psychological interpretations (e.g., psychodynamic, behavioural) and provides a description of processes which are evident, irrespective of whether such processes are interpreted from a structural, behavioural or

psychodynamic point of view. Such an over-arching theoretical perspective may be helpful to maintain, given the complexity of the illness.

The second-order cybernetic interpretation of the case studies, should be viewed in the light of such theories (cybernetic), which advocate that the observer cannot be separated from what is observed (Keeney, 1983). Popper (cited in Keeney & Morris, 1985) proposed that our findings are directed by our theories, as opposed to our theories being directed by our research findings. Second-order cybernetic theorists (Keeney & Morris, 1985) maintain that researchers often "construct" the phenomena which fit the researcher's theoretical system, and that there are many different ways of describing the same object (Steier, 1991b). According to Steier (1991a) in the process of describing objects, some of the observations are emphasised while others are de-emphasised. Auerswald (1987) argues that whenever we construct a theory or observations, we are "editing the Universe" and thereby providing an edit which is ours alone - to assume that this "edit" is in any way representative of reality, is naive. Similarly, Watzlawick (1984) speaks of the "invented reality" and says that there are more or less useful interpretations of reality, however, it is a mistake to assume that what is useful is true.

Second-order cybernetic theories and post-modern doctrines, consider knowledge and "reality" to be multiple, fragmented, context-dependent and local (Hare-Mustin, 1994; Sarup, 1989). This is in contrast to the doctrine of realism which advocates that objects in the world exist independently of the observer and the observer's discourses thereof (Greenwood, 1992). Postmodernists argue that "reality" is one of many possible realities (observer-dependent) and descriptions of reality are viewed as one of many possible descriptions (Schwandt, 1994). These second-order perspectives have informed the presentation of the cases, as well as the emphasis in the preceding discussion, that the second-order interpretation is one of many possible interpretations.

Case studies are in essence narratives or stories (about patients) which have been constructed in the therapeutic process. Freeman (1993) states that stories are shaped by what the author edits out of the story. According to Zimmerman and Dickerson (1994) in the process of creating stories, people look backwards for memories and information which

support the dominant story. Information which does not fit the story is edited "out". Freeman (1993) postulates that we read and interpret stories according to our own expectations of how a story should look (our dominant psychological theories) and it is thus important to be aware of our own interpretive contexts. Sarup (1989) points out that the same story can be interpreted differently.

In terms of the above case presentations, the question does arise as to whether anything meaningful can be said in terms of the generalisation of findings. The latter issue raises the debate regarding "legitimate" knowledge. Lyotard (cited in Sarup, 1989) says that there have always been two kinds of knowledge - scientific and narrative. According to Lyotard (cited in Sarup, 1989) narrative knowledge has always been a subjugated form of knowledge which has been accorded less status than that of scientific knowledge. Morrow and Brown (1994) state that there have traditionally been two competing views of what kind of science the human sciences should be. The first view proposes that the human sciences should emulate the most advanced natural sciences (e.g., biology, physics); whereas the second view holds that the human sciences should take a humanistic approach. Morrow and Brown, however, point out that one of the distinguishing features between the natural sciences and the human sciences is the problem of interpreting meaning. Within the discussion of the case studies, the focus was upon a description of process, rather than upon interpreting the meaning of the symmetrical processes. The latter will, however, be considered in the final discussion.

Dare et al. (1995, p. 31) state that "many people in the fields of mental health espouse a strong adherence to experimental, scientific methods...and consider only that which has been experimentally tested as 'really true'". Various authors (Dare et al., 1995; Speed, 1995) have, however, argued that clinical and research findings can be complementary activities which inform one another. Cybernetic approaches to anorexia nervosa were, according to Dare et al. (1995, p. 31-32), "sturdily mathematical" with "strongly scientific origins". However, little empirical research has been conducted by family therapists. The case presentations within this report are subject to the latter criticism. However, as Dare et al. point out, clinical studies facilitate the description of patterns which might otherwise be over-looked in empirical studies. The description and identification of such patterns can then be investigated in empirical (and

quantitative) studies to determine to which groups and sub-groups the patterns apply (Dare et al., 1995). Case studies when viewed from this perspective do have utility if conceived of as part of a process, rather than an end in themselves.

On a final note, case presentations raise ethical issues pertaining to the maintenance of patient anonymity (and confidentiality). Commonly, names and identifying details are changed in order to protect the patients (Bruch, 1988; Sours, 1980). Other approaches have, however, also been taken. Bruch (1988), for example, identified common themes among patients and incorporated these into composite presentations. Sours (1980) approached the problem by inter alia, creating a fictional narrative, such that the essence of anorexia nervosa would be portrayed without the risk of exposing patients' identities. However, even if the identities of patients are disguised from an outsider's point of view, the question still remains as to whether patients would be able to identify themselves in case reports (Sours, 1980). Within the case presentations in this report, a decision was made to weave the factual case material into a fictional narrative such that the essence of the interactional patterns would be portrayed, without reference to details which would allow for the identification of the patients or their families. While this may have succeeded in masking the patients' identities from an "outsider's" point of view, the question does remain as to whether the patients might still recognise themselves in the narrative, particularly "Gabrielle", given that her narrative was incorporated into the case presentations. The young age of the two patients made it difficult to consider obtaining informed consent to use the material, as it is unlikely that either of them would have been able to make an informed decision. Thus a decision was made to use the material for illustrative purposes and to attempt to present the material in such a way that the patients' identities remained disguised. In addition, to the latter, a unanimous decision was made by the ethical and research committee of the institution concerned, that the case material could not be used without the consent of the guardians of the patients. Based on this decision, consent was obtained from the guardians of the patients, for the use of the file material for research purposes. It is hoped that the disguise of the case material, as well as the consent of the guardians has served to protect both the patients and their families, while communicating clinical findings which may not have been evident in an empirical study.

CHAPTER 4

DISCUSSION

Various patterns of family and individual functioning emerged in the aforementioned cases which confirmed the findings of others (Bruch, 1978; Minuchin et al., 1975; Minuchin et al., 1978; Selvini-Palazzoli, 1985b). For example, difficulties with separation and individuation were evidenced, as were maturation fears. In addition, the mother-daughter relationships appeared to be enmeshed, such that there was a lack of differentiation - reflected in a seemingly exchangeable sense of self. One of the most striking aspects of the cases was the sequencing and synchronicity of dieting in the mother-daughter pairs. It cannot be said with certainty that the mothers evidenced an eating disorder in terms of the DSM-IV diagnostic criteria. However, they did exhibit behaviours (dieting) regarded as a major risk factor for the development of an eating disorder (see Bryant-Waugh, 1993a; Halmi, 1995). In addition, both mothers had recently lost a significant amount of weight.

As mentioned in the introduction to this report, the names and meanings of disordered eating behaviours have changed across time. Thus, if one looks beyond the naming of such behaviours and focuses at a very rudimentary level on the description of the behaviour, what emerges, is behaviour aimed at the reduction of body fat through the restriction of dietary intake. With reference to the shared manifestation of such behaviours in the two mother-daughter pairs presented in this report, the question arises as to the nature of the emergence of such behaviours. In other words, did an inter-generational transmission of disordered eating behaviours occur and if so, what was the nature of this transmission?

Genetic epidemiological studies and clinical reports (Holland et al., 1988; Hsu, 1983, Strober et al., 1990) suggest that there is a tendency for anorexia nervosa and disordered eating behaviours to cluster in families - across generations. Such observations have raised the contentious question as to whether the inter-generational transmission of such disorders, is

genetic or environmental (family environment) in nature. Evolutionary psychologists (Cosmides & Tooby, 1998) argue that the premises of such dichotomous questions are flawed. In the view of evolutionary psychologists (Cosmides & Tooby, 1998, p. 20) the question posed by behavioural geneticists (whether genes or family environment contribute more to behaviour) has no answer. Cosmides and Tooby (1998, p. 21) state that such questions are meaningless because every aspect of an individual is the joint product of genes and environment - "to ask which is more important, is like asking which is more important in determining the area of a rectangle, the length or the width". Similarly the question as to whether, for example, the maturation fears or the mother-daughter dieting (in the case presentations) was *more important* in precipitating the daughter's anorexia nervosa, also cannot be answered. The case material does, however, suggest that family environmental factors (mother-daughter dieting) were *important* in the precipitation of the illness. These findings support reports (Alessi et al., 1989; Bruch, 1978; Crisp et al., 1980; Jacobs & Isaacs, 1986; Kent et al., 1982; Lieberman, 1995; Minuchin et al., 1975; Schwartz & Barrett, 1987) which suggest that the family environment plays an important role in providing a context (dieting; preoccupations with body shape, size and appearance) which may predispose towards anorexia nervosa, in terms of the *content* (food, the body) of the symptoms.

With reference to the *processes* surrounding the symptoms, the case material when viewed from a cybernetic perspective, suggests that the patterns and connections surrounding the onset of illness, were reflective of a symmetrical interactional tendency. Such processes were also evidenced in other aspects of family functioning, such as blame-shifting. It was proposed (in the discussion following the case studies) that these findings, together with literary reports (Bruch, 1988; Norris, 1979; Selvini-Palazzoli, 1985b; Raymond et al., 1993; Schwartz & Barrett, 1987) suggest that the choreography of the illness is symmetrical in nature. In other words, anorexia nervosa reflects a symmetrical dance with the world, which the anorexic stages upon her body. The principal suggestion within this conceptualisation is that the *process* of anorexia is in essence, *about* symmetry. In other words, the symmetry manifests *through* anorexia nervosa. The main implication of this perspective for intervention is simply that the symmetrical processes associated with the illness should be targeted in psychological interventions. Watzlawick et al. (1967) state that symmetry is, in itself, not "good" or "bad"

and that most relationships contain both symmetrical and complementary processes. However, problems arise when relationships become dominated by either of these two patterns. This is particularly so when symmetrical processes are acted out around food intake. As Snyders (personal communication, May 20, 1998) points out, the anorexic is "blind to the seduction of symmetry" in terms of the "potential loss of life which lurks behind the pyrrhic victory" of her symmetrical dance.

In terms of the conceptualisation of anorexia nervosa as an illness of symmetry (at a process level), the question does arise as to the origin of the symmetry. Within the two case studies, the symmetry manifested in symptoms, more or less at the time that early pubertal changes became evident. Symmetrical processes were also, however, evident in other aspects of family functioning. It is thus not clear whether the tendency towards symmetrical interactions pre-dated the onset of symptoms. Selvini-Palazzoli (1985b) found that competitive symmetrical processes within the parental relationship pre-dated the onset of anorexic symptoms. Other authors (Norris, 1979, p. 989) state that the symmetry ("competitive striving") evidenced by anorexics stems from individual psychological characteristics ("underlying, controlled hostility"). The demographics of the illness, however, suggest that the symmetry evidenced by the anorexic, reflects interactional processes which include, but also extend beyond the individual characteristics of the anorexic. Bruch (1978, p. vii) states that anorexia nervosa "befalls" the "daughters of well-to-do, educated and successful families" who have high financial and social status; families who do not fit this demographic profile are success-oriented and upwardly mobile (Bruch, 1978, p. 24). Thus, while the anorexic may act out symmetrically in relation to food, it is possible that the "symptoms of symmetry" are present in other family members albeit manifested in other areas, such as over-achievement. In other words, it is possible that the reported "success" within "anorexic families" may reflect the very same symmetrical processes which enable the anorexic to be exceptionally successful at dieting. Empirical studies on larger groups, are needed to determine if this is so. As mentioned previously, Selvini-Palazzoli (1985b) argued that symmetrical processes were evident within the parental relationship within families with an anorexic child. Similarly, Sluzki and Beavin (1977) found that parents of children with (unspecified) psychosomatic illnesses exhibited marked symmetry within their marital relationship. The findings of this

report suggest that symmetrical processes extend beyond the parental relationship and may permeate all family relationships, eventually manifesting in anorexia nervosa. However, the findings and proposals within this report are limited given that they are based upon only two case studies. Notwithstanding these limitations, the case material does, however, suggest that family environmental factors are important at both a content (food & body) and process (symmetry) level in the emergence of anorexia nervosa. Empirical research is, however, needed to determine whether symmetrical processes are evidenced in larger groups of anorexics; whether such processes are part of the interactional tendencies within the family systems of anorexics; and whether such tendencies are multi-generational in nature. Snyders (personal communication, June 3, 1998) suggests that cross-generational processes of symmetry, competition and individuation, be investigated by means of three of four generational studies in order to determine whether such processes do produce an "anorexic person" and how long it takes, for this to happen. Research (Holland et al., 1988; Strober et al., 1990) does suggest that anorexia nervosa "runs" in families, what needs to be clarified is how this transmission takes place within families.

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