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# Conceptualization of anorexia nervosa : a theoretical synthesis of self-psychology and family systems perspectives

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Molly Gray  
Conceptualization of  
Anorexia Nervosa: A  
Theoretical Synthesis  
of Self-Psychology  
and Family Systems  
Perspectives

## ABSTRACT

Anorexia nervosa is a life-threatening psychiatric disorder that has increased in diagnostic prevalence over the last century. Findings suggest that individuals at greatest risk are females between the ages of 15-22, who demonstrate heightened levels of perfectionism and a need for control. This theoretical thesis hopes to provide clinical social workers and other mental health professionals with a deeper understanding of the psychological, familial, and developmental factors contributing to the onset of the disorder in order to increase the effectiveness of future treatment. Self-psychology will be examined to offer a possible developmental and psychological framework for understanding the emotional challenges and distorted thought processes of the anorexic patient. Bowen's adaptation of family systems theory will be used to support the resilience and strength of the patient's family unit by uncovering and addressing dysfunctional patterns. The aim of this thesis is to suggest that approaching treatment for anorexia nervosa through the synthesized lens of self-psychology and family systems theories may help address the multifaceted and deeply engrained aspects of this complex disorder.

**Conceptualization of Anorexia Nervosa: A Theoretical Synthesis of Self-Psychology and  
Family Systems Perspectives**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2014

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## TABLE OF CONTENTS

ACKNOWLEDGEMENTS ..... ii

TABLE OF CONTENTS ..... iii

### CHAPTER

I INTRODUCTION .....5 - 9

II METHODOLOGY .....10 -16

III PHENOMENON .....17 - 43

IV FIRST THEORY: SELF-PSYCHOLOG .....44 - 55

V SECOND THEORY: FAMILY SYSTEMS .....55 - 66

VI CONCLUSION .....67 - 84

REFERENCES .....85 - 94

## **CHAPTER I**

### **INTRODUCTION**

Anorexia nervosa is a life-threatening psychiatric disorder that has increased in diagnostic prevalence over the last century (Hoek, 2006). With a mortality rate that exceeds any other psychiatric illness, anorexia remains one of the more complex disorders to treat (Hurst, Read & Wallis, 2012). Medical understanding of anorexia nervosa has evolved in recent years. However, psychological treatment techniques and etiological factors still remain largely inconclusive. Both socio-cultural and feminist theories have been applied to the disorder in the hope of establishing preventative interventions. These theories attribute increased prevalence rates to the unrealistic beauty standards created and enforced by popular culture. However, documentation of cases pre-dating televised and printed media have discredited these theories as the sole contributing factors (Brumberg, 1988). Recent neurological research has helped strengthen medical understanding of the possible biological risk factors but have yet to be accompanied by effective interventions. High relapse rates and low incidence of life-long recovery have suggested that current treatments are failing at addressing the true source of the problem (Goodsitt, 1997). Previous treatment regimens have frequently focused on addressing solitary contributing factors, missing the multifaceted environmental, developmental, and psychological aspects that have contributed to the development of anorexia nervosa (Brumberg, 1988).

## **History and Definition**

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013) defines anorexia nervosa as "persistent energy intake restriction; intense fear of gaining weight or of becoming fat; and a disturbance in self-perceived weight or shape" (APA, 2013). The main diagnostic criterion for anorexia nervosa is a body weight below the expected age, sex, and height of the patient (APA, 2013). Anorexia nervosa is separated into two subcategories: restricting type and binge-eating/purging type. The following chapters will focus on both manifestations of anorexia, as research has established that these categories are often fluid, with patients transitioning between sub-types throughout the treatment process (APA, 2013).

## **Connection to Social Work Practice**

Anorexia is the third most common chronic illness amongst adolescents in the United States (Robinson, Strahan, Wilson & Boachie, 2012). The disorder affects individuals across all age groups and genders but is most common in females 15-22 years of age (Eisler, Simic, Russel & Dare, 2007). Hoek (2006) reports that over the last century the rates of those diagnosed with anorexia nervosa has increased to an estimated .3% of the population and is still on the rise (as cited in Hurst, Read & Wallis, 2012). A longitudinal study revealed that 5% of those diagnosed with anorexia will go on to die from it, and less than 50% of those who receive treatment will achieve full, life-long recovery (Steinhausen, 2002).

This theoretical thesis hopes to provide clinical social workers and other mental health professionals with a deeper understanding of the psychological, familial, and developmental

factors contributing to the onset of the disorder in order to increase the effectiveness of future treatment. It will outline Kohut's theory of self-psychology and Bowen's family system's theory in order to assess their possible application to anorexia nervosa. It will go on to provide a hypothetical case example to see, if synthesized, these two theoretical perspectives may provide a more informed framework for clinical practice.

### **Failures of Current Treatment**

Research has suggested that a need for control is a key factor in the onset of anorexia nervosa, making patients' resistance to treatment common (Williams & Reid, 2012). Early theories developed by Minuchin, Rossmann & Baker (1978) assigned blame beyond the individual, attributing adolescent onset to poor parenting styles and disrupted attachments with primary caregivers. Treatment adapted from Minuchin et al., (1978) family systems theoretical approach focused on finding the source of the problem rather than addressing the patient's fractured sense of self (Goodsitt, 1997). A large majority of outpatient treatment options involving family systems have focused on the failures of family functioning instead of utilizing family strengths and resiliency factors (Eisler et al., 2007; Lock, Le Grange, Agras & Dare, 2001; Robinson et al., 2013; Steinhilber, 2002). This has inhibited the cooperation of family members throughout the patient's recovery process (Goldenberg & Goldenberg, 2013). Bowen's family system theory could provide a framework that helps to explain a member's contribution to family problems. Deeper understanding of relational patterns could allow for system change by emphasizing the effect each member has on the unit as a whole. Consideration of family history could promote members taking responsibility for their actions and current roles within the family. This may stimulate deeper empathy for the individual in treatment, affording them more familial support throughout the treatment process (Walsh, 2012).



Inpatient treatment options, for more severe cases of anorexia nervosa, focus on immediate weight restoration in order to avoid debilitating health risks. Mitchell and Crow (2006) explain that chronic malnutrition can result in the loss of menstruation cycle, peripheral edema, and osteoporosis. Eating Disorder specialist Alan Goodsitt (1997) suggests that inpatient hospitalization has proven to be successful at restoring patient's weight but neglects to address the distorted thoughts and depleted self-esteem of the anorexic patient. Goodsitt (1997) argues that these treatment options are cost effective and capable of addressing large numbers of patients but often result in a "person who suffers as before, but looks normal - an anorectic clothed in weight" (p. 311).

Alternative outpatient mental health therapies such as Cognitive Behavioral and Dialectical Behavioral therapies have been used to treat individuals with pervasive eating disorders. It is important to note that there are a multitude of treatment formats utilized to address anorexia symptoms. It is the intention of this theoretical exploration to better understand the etiological factors of anorexia nervosa in order to provide a synergized lens that may help practitioners use treatment options that are more effective.

### **Overview of Theoretical Frameworks**

This research investigation will outline two theoretical frameworks that may help inform more effective treatment options. An outline of family systems theory may lead to therapeutic practice approaches that support the resilience and strength of the patient's family unit by uncovering and addressing dysfunctional patterns. An outline of self-psychology theory may provide a conceptual framework for understanding the anorexic patient's sense of self and suggest practice interventions aimed at the restoration and reinforcement of healthy self-esteem.

Bowen's adaptation of family systems theory will be used to demonstrate how "stressful events, environmental conditions, and problems of an individual member affect the whole family as a functional unit" (Walsh, 2012 p. 29). This theory is useful in viewing treatment options for anorexia, as it is most commonly diagnosed in adolescence and has deep effect on other members of the family (Eisler et al., 2007). By understanding the patterns of behavior that exist in the anorexic patient's family system, clinicians can help to promote higher resiliency and functioning in the family unit as a whole.

Self-psychology theory may help to explain the developmental and emotional deficiencies that are associated with anorexia. Viewing treatment through this theoretical lens could shed light on the aspects of the disorder less apparent to family members and therapists alike. Research has shown that anorexia often coincides with a distorted thought process, depleted self-esteem and an inaccurate perception of body weight (APA, 2013). Through the use of Kohut's theory of self-psychology, developmental factors that contribute to cognitive distortions and individual vulnerabilities may be better understood. Treatment can be informed by this theory, placing emphasis on the need to specify treatment to the individual's body image distortion and low self-esteem by reiterating the importance of therapeutic empathic mirroring and supportive counseling (Wassell-Kuriloff & Rappaport, 1987).

Anorexia nervosa is a complex disorder that continues to perplex treatment. This thesis intends to provide an alternative way to understand the symptoms of the patient in order to provide a more inclusive treatment approach. The following chapter will introduce the strengths and limitations of each theoretical component as well as provide the ways they may be used in application to anorexia nervosa.

## **CHAPTER II**

### **METHODOLOGY**

This chapter will introduce the theoretical frameworks chosen to better understand anorexia nervosa, offering their relevant applications to future treatment. It will offer a brief description of the underlying concepts of family systems theory and self-psychology, highlighting the strengths and limitations of each. The chapter will conclude with a presentation of personal biases, exploring areas of the thesis which may have been influenced by the individual experiences and clinical perspectives of the writer.

#### **Theoretical Frameworks Defined**

##### **Family Systems Theory**

Family systems theory focuses on family dynamics and the ways the family system's functioning affects its individual members (Goldenberg & Goldenberg, 2013). This theory holds that changes to the individual patient cannot be made without the cooperation and adaptation of the system as a whole. Family systems theory looks at individual anxiety levels as manifestations of family dynamics and the family member's relationship patterns with other members of the family (Goldenberg & Goldenberg, 2013). Family systems theory will help to better conceptualize how family functioning can contribute to an individual's symptoms, focusing treatment on addressing the destructive relational patterns that have inhibited members from successfully supporting the individual in treatment.

Core concepts underlying family systems theory are emotional fusion and the level of differentiation between family members (Brown, 1999). Kerr and Bowen (1988) describe differentiation as the ability to develop individual autonomy while simultaneously maintaining emotional connection to the family unit. Families that exhibit unsuccessful differentiation exhibit more emotional fusion and enmeshment. Enmeshed families demonstrate a heightened demand of energy from its members, disadvantaging the unit as a whole when responding to stressful events. Research suggests that families with enmeshed organizational patterns are more susceptible to psychological disorders, making identification and resolution of enmeshment and fusion an imperative part of the treatment process (Brown, 1999).

**Strengths and limitations of family systems theory.** This theoretical underpinning may be extremely useful in understanding anorexia, as the disorder most commonly materializes in early adolescence, a developmental period universally characterized by more differentiation and less psychological enmeshment (Eisler et al., 2007). The guilt presented by many anorexic patients often results from developmental pressures related to “becoming a person, developing a selfhood, experiencing pleasure and separating from parents” (Goodsitt, 1997, p. 218). Understanding the ways in which a family system can either contribute to or alleviate the level of stress in adolescent development and promote individual identity formation may be useful for the conceptualization of treatments.

The weakness in this theory lies in its tendency to inform treatments that rely on the inclusion of the immediate family system. Studies supporting the involvement of the whole family system have paid little attention to the growing rate of divorce and the level of family involvement necessary for treatment to work. Additionally, if this theory is not understood from

a blame reduction perspective, treatment informed by this theory can place unnecessary shame and guilt on both the patient and the family.

### **Self-Psychology**

Self-psychology is based on the concept that the child develops into a cohesive adult in response to the relationships held with initial caregivers. Heinz Kohut (1971) believed that individual vulnerabilities that manifest in later life stemmed from aspects of early childhood experience and the failure of successful primary relationship formation. Kohut felt that individual self-esteem was dependent on caregivers' initial ability to provide self-object relationships for their child.

Kohut (1978) defines self-objects as follows:

Self-objects are objects which we experience as part of our self; the expected control over them is therefore closer to the concept of the control which a grown-up expects to have over his own body and mind than to the concept of the control which he expects to have over others. There are two kinds of self-objects: those who respond to and confirm the child's innate sense of vigor, greatness, and perfection; and those to whom the child can look up and with whom he can merge as an image of calmness, infallibility and omnipotence. The first type is referred to as the mirroring self-object, the second as the idealized parent imago (p. 414).

The development of a "cohesive self" is contingent on a caregiver's initial ability to respond appropriately to the child's early feelings and basic needs. Ideal self-object relationships ensure the child's place and importance in the world, paving the way for future confidence and autonomy (Kohut, 1978). Ideal self-object relationships promote an adult with a "cohesive self"

with the ability to experience failure and success without it inherently damaging their self-esteem. Cohesive adults with successful initial relationships have developed the ability to strive for power, set goals, and identify individual talents and skills (Kohut, 1978). If these three aspects are not provided for and “faulty interaction between child and his self-objects (occur),” a fractured self will form (Kohut, 1978, p. 414).

This theory suggests that individual self-esteem is dependent on one's opportunity to create and maintain healthy self-object relationships during childhood, rooted in the caregivers' empathic responses. Individuals whose endowment or whose environments are not able to contribute sufficiently to meet these early needs have been shown to repeat destructive patterns of dependency and are more susceptible to specific diagnoses of the self (Kohut, 1978). Kohut's theory of self-objects can be useful in understanding the thought process and manifestation of behaviors in anorexic patients as many show an inability to create or maintain cohesion and healthy self-esteem.

Studies have shown that many anorexic patients lack basic self-regulating functions, relying on the eating disorder to mask underlying issues with low self-esteem, emotional dysregulation, and an inability to self-soothe. The theory of self-psychology may help to explain why anorexic patients tend to demonstrate a “fragmented self” and an inability to express or meet their own needs (Wassel-Kuriloff & Rappaport, 1987). Individuals may be more susceptible to the disorder when self-object experiences in early childhood are less than optimal, the result being a decreased ability to meet or express internal desires and basic needs (Bachar, 1998; Williams & Reid, 2011). Anorexic patients are often people pleasers, who meet the self-object needs of others, while simultaneously denying their most basic need through the restriction of food intake (Goodsitt, 1997).

Self-psychology will be examined to offer a possible developmental and psychological explanation for the emotional challenges and distorted thought processes of the anorexic patient. This theory could help to explain how anorexia becomes a maladaptive mechanism, utilized by the patient to hide a depleted sense of self, fractured by early caregiver relationships. Further understanding of basic self-object needs can help explain how self-starvation may be a behavioral manifestation of the inability to meet one's individual, emotional needs.

This theory may provide a possible explanation for the anorexic patient's common resistance to treatment, as well as the low success rate for long-term recovery. Self-psychology can help to explain how life without the disorder could actually threaten the patient's sense of self, eliminating the defense (food restriction) that has protected her from addressing deeper feelings of emptiness and worthlessness (Goodsitt, 1997). Understanding the vulnerabilities of the anorexic patient and the need for a strong therapeutic relationship that meets previously unmet self-object necessities, could be essential for successful treatment.

The self-psychology theoretical perspective has informed treatment by utilizing two components: empathic mirroring and interpretation. Use of the first (empathic mirroring) has been shown to be highly productive and influential in the treatment of anorexia (Wassel-Kuriloff & Rappaport, 1987). Understanding the need for therapeutic, empathic mirroring is useful in the treatment of anorexic patients because of the typically less than optimal mirroring experienced by the anorexic in early development. Due to the risks and isolating factors present with this illness, partly because of the distortions in cognitive processes, empathic interpretation of faulty thinking can be helpful and even life-saving.

**Strengths and limitations of self-psychology theory.** Self-psychology can help therapists better understand anorexia by looking at the disorder as a manifestation of insufficient

primary self-object relationships. The more chronic the disorder becomes, the more difficult it is to treat. Research has suggested that unlike other disorders, self-starvation paradoxically becomes a way for the patient to maintain internal self-preservation. A self-psychology framework may help further explain the resistance that occurs in the patient when the disorder is threatened by treatment. Treatment informed by this theory would support separating the individual from the disorder, once an empathic relationship between therapist and patient has been built and the patient's self-cohesion begins to emerge more clearly. Understanding how to navigate and avoid patient resistance by emphasizing the role of the therapist's use of herself as a temporary self-object may encourage more positive outcomes (Goodsitt, 1997; Wassell-Kurilloff & Rappaport, 1987). Limitations of using self-psychology as a guiding framework for practice suggests that the treatment could be prolonged and demanding - requiring time and stamina on the part of both therapist and patient.

The final chapter of this theoretical exploration will provide a summary of the main points developed throughout the thesis. This discussion section will outline the key components of each theory and offer a synthesized formulation for viewing future treatment. A hypothetical case example will be used to demonstrate how each theory separately may be applied to a particular case. In addition, a synthesis of the two theoretical frameworks will be applied to the case material to demonstrate their potential, when used together, to provide a comprehensive treatment format for practice.

### **Personal Biases**

Perhaps the most salient bias of this writer is a personal interest in family systems theory from exposure to the positive effect it can have on treatment. The writer views family systems theory through a strength based lens, running the risk of overlooking dysfunction and pathology.



Use of Bowen's family system theory will help to address these biases by offering a more comprehensive understanding of the dysfunctional patterns that can lead to mental health issues. Additional biases lie in a personal interest in self-psychology as an existing development theory that offers the most explanatory power in designing treatment for anorexia nervosa. This bias may be influenced by my Euro-American upbringing. My focus on self-identity and the natural development of individuation from the family unit may be centered in Euro-American ideals and cultural traditions. Understanding my own personal biases and the cross-cultural factors that may equate to a patient's difference in ideals is an important consideration in beginning this theoretical analysis.

The following chapters will outline the history of anorexia, particularly as it pertains to the field of Social Work practice. It will review a systems approach (Family Systems Theory) as well as a psychological and developmental approach (Self Psychology). And it will provide a synthesis of these two approaches to suggest an effective approach to the treatment of those with anorexia nervosa.

## CHAPTER III

### PHENOMENON OF ANOREXIA NERVOSA

Statistics show that nearly 24 million Americans are affected by eating disorders (Renfrew Center Foundation for Eating Disorders, 2003) and that these life-threatening diagnoses are becoming more prevalent in the United States (Sue, Sue & Sue, 2010). It is estimated that somewhere between .5 – 3.7% of women will suffer from the eating disorder subtype, anorexia nervosa, in their lifetime (Anorexia Nervosa and Associated Disorders, 2014). While initial research had suggested that anorexia remained most prevalent in white upper middle class females, diagnosis rates amongst Hispanic American and Native American females are on the rise (Gilbert, 2003; Lee & Lock, 2007; Sherwood, Harnack & Story, 2000; Story, Neumark-Stainzer, Sherwood, Stang, Murray, 1998; Wax, 2000). Diagnosis rates are most prevalent in adolescent females, though recent research has suggested that male cases have increased in recent years (Sue et al., 2010).

Prognosis for recovery from anorexia has proven to be highly affected by the duration of the illness, with more prolonged starvation episodes drastically increasing the risk of relapse and death. Side effects of long-term starvation range from loss of menstrual cycle to more chronic issues such as osteoporosis, anemia, compromised immune function, and death (Misra et al., 2004). Anorexia continues to hold the highest death rate of any other psychiatric disorder with a mortality rate estimated around 19%. Deaths associated with the disorder are often sudden and result from complications brought on by prolonged malnutrition. Medical professionals suggest that these statistics may be inaccurate as death reports often cite the cause of death (e.g., suicide,

heart failure) instead of the disorder itself (Andersen, 2007; *Anorexia Nervosa and Associated Disorders*, 2014; Panagiotopoulos, McCrindle, Hick, & Katzman, 2000).

For anorexic patients who do seek treatment, about 2% will continue to experience a lifetime prevalence of disordered eating behaviors (Oltmanns et al., 2009). Inpatient treatment options in the United States currently cost between 500 to 2,000 dollars a day. In one state the high cost and lack of insurance coverage has caused about 80% of those who access care to be discharged from inpatient programs prior to addressing the underlying psychological aspects of the disorder (Department of Mental Health South Carolina, *Eating Disorder Statistics*, 2013). Although certain states have passed parity laws that provide equal treatment for mental illness diagnosis, most state policies continue to exclude reimbursement for eating disorder treatment (*Anorexia Nervosa and Associated Disorders*, 2014).

Conceptualization of anorexia's etiology has identified a multitude of factors including familial, socio-cultural, biological, psychological and interpersonal perspectives. Efforts to gain a better understanding of anorexia nervosa have progressed in the past four decades, but new findings have also created new questions. Poor treatment outcomes, patients' resistance to seeking help, and therapists' limited understanding of the etiological aspects that contribute to onset have perpetuated and prolonged ineffective treatments (Duvvuri & Kaye, 2009).

With a diagnosis that continues to grow and perplex clinicians, there is a need for a theoretical framework that accounts for multiple etiological factors. In the words of eating disorder specialist Hilde Bruch (1973) "The ambition to 'explain' such a complex picture with one psychodynamic formulation has resulted in imposing stereotyped explanations on a condition that defies such a simplistic approach" (p. 215). In support of Bruch's perspective this chapter will examine some varying perspectives on the origins of the disorder, as well as suggest

the potential for a more focused, inclusive, and informed viewpoint on future treatment through the use of family systems theory and self-psychology.

### **History and Rise of Anorexia Nervosa Diagnosis**

Early documentation shows that, while anorexia was identified as early as the 1870s, the disorder did not rise to national awareness as a severe psychological disorder until the 1980s (Brumberg, 1988). In the 1970s popular media sources, such as Time, People, Seventeen and the New York Times, began to identify what was called "the bizarre starving disease." With little knowledge about the prevalence or cause of the illness, mass-media created a storm of misinformation that targeted white-upper middle class families. Medical publications utilized public fear to promote poorly supported and expensive inpatient hospitalization cures (Brumberg, 1988).

Initial epidemiology of anorexia focused on the percentage of cases reported in upper-middle class families (Brumberg, 1988). Theorists blamed a rise in the diagnosis on an increase in the United States economy after World War II. Brumberg suggests that "in the postwar culture of affluence many aspects of personal behavior were transformed: sexuality, relations between the generations, forms of family life, gender roles, clothing, even styles of food and eating" (p 11). In an effort to explain the geographic and class division of those diagnosed, theorists suggested that the ability to deny food was reliant on its prevalence and accessibility. This hypothesis sparked the theory that girls and women from affluent families and countries were at the highest risk of becoming diagnosed (Brumberg, 1988).

By the mid-1980s anorexia self-help books and the death of a celebrity role model (Karen Carpenter) began to further expose the disorder and the serious consequences of prolonged

starvation (Brumberg, 1988). Increased public attention precipitated by the growing number of cases demanded effective treatment options. Researchers and pharmaceutical companies began to collaborate in an effort to identify a cause and cure. Brumberg writes, "Because anorexia nervosa and bulimia were marginal (if not unknown) diseases until very recently, and because of their restricted age, gender, and class clientele, those who serve the cause of eating disorders must work aggressively to convince the public of their seriousness, especially when the competitors are AIDS, Cancer, and Alzheimer's" (p. 19). In 1985, in response to an increased demand for therapeutic resources, the Renfrew Center opened in Roxborough, Pennsylvania as the first primary residential facility for the treatment of eating disorders. Treatment focused on immediate weight restoration, promising a cure for patient starvation. Attempts to treat the disorder offered a temporary band aid but fell short of addressing the psychological issues underlying the disorder (Brumberg, 1988).

Advancements in research funding and study sample sizes have helped pinpoint key components often associated in the development of anorexia nervosa. There are still many hypotheses surrounding how, why, and who anorexia nervosa affects, and it is still unclear whether any one treatment is beneficial at mitigating long-term body distortions. As the number of reported cases continues to breach racial, social, and economic barriers, review of available research on developmental, social-cultural, and familial factors contributing to a diagnosis of anorexia would be useful. Joan Brumberg (1988) argues that, "How one conceives the cause of anorexia nervosa has a critical impact on treatment" making it important to understand the multifaceted aspects that have been studied and proven to increase one's likelihood of suffering from the disorder (p. 24).

## **Medical and Psychiatric Definition**

Medical and psychiatric understanding of anorexia is defined by The DSM-IV TR, 2014 as:

- 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 percent of that expected)
- Intense fear of gaining weight or becoming fat, even though underweight
- Disturbance in the way 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
- In postmenarcheal females, amenorrhea, the absence of at least three consecutive menstrual cycles (American Psychiatric Association, 2000, p. 589).

Medical professionals have identified two sub-types of anorexia nervosa. Individuals classified as the restricting sub-type have no significant episodes of binge eating and purging behaviors within the past month of diagnosis. The binge-eating/purging sub-type demonstrates repeated binge/purge episodes in which an individual consumes a large portion of food, and then tries to rid themselves of the calories through the misuse of laxatives or induced vomiting (Oltmanns et al., 2009). Studies have found that individuals often move between sub-categories and that about half of individuals diagnosed with anorexia demonstrate aspects of binge and purge behaviors at some point in the treatment process (Eddy et al., 2002)

**DSM - 5 changes.** It is important to note that the newest Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) has made changes to the

wording and conceptualization of the previous medical diagnosis. The modifications have removed the diagnostic criterion amenorrhea, the medical term for the absence of three consecutive menstrual cycles. The criterion was removed after therapists and medical professionals labeled it a useless measure for diagnosis, suggesting that its absence depended on a multitude of other biological and developmental factors (Grohol, 2013). APA has also removed the word "refusal" to describe criteria one. This was decided after research suggested that "refusal" implied intent on the part of the individual, and was difficult to measure. These changes are a step forward for medical conceptualization of the disorder. However, the remaining diagnostic criteria can at times overlook patients of "normal weight" who continue to struggle with deeper psychological deficits (Grohol, 2013).

**Physical complications.** Self-starvation wreaks both short and long-term consequences on the body. Some of the symptoms associated with emaciation are cardiac arrhythmias, low blood pressure, and slowed heart rate. Patients struggling with the disorder often demonstrate a loss of energy, dehydrated skin, brittle hair, and in more extreme cases hypothermia (National Institute of Mental Health, 2007). Irreversible side effects of prolonged starvation include osteoporosis, vertebra contraction, stress fractures, and heart weakening due to the body's use of the muscle as a source of protein to support the needs of the starving body (Sue et al., 2010).

**Associated diagnoses.** A number of other psychiatric diagnoses have been associated with anorexia. Dual diagnoses of Depression, Generalized Anxiety, and Obsessive Compulsive Disorders have been found to be most commonly associated with anorexia nervosa. Data suggests that 40-50% of individuals with eating disorders have a diagnosis of depression, 30-40% have generalized anxiety, and 33% have personality disorders (Jackson, 2013). Obsessive compulsive behaviors are most commonly represented in obsessive thoughts towards food,

exercise, and the pursuit of thinness (Rogers & Petrie, 2001). Personality disorders present in common traits of "introversion, conformity, perfectionism, and rigidity" (Jackson, 2013).

Researchers Westen & Harnden-Fischer, (2001), suggest that "interpreting these relationships has been difficult, as they could (1) represent the misfortune of having two or more disorders by chance, (2) indicate that anorexia is an expression of a personality disorder, or (3) be the result of common environmental or genetic factors that underlie both anorexia and the personality disorder" (p. 3).

### **Biological Factors**

There are still no FDA approved pharmacological drugs used to treat anorexia (Agency of Healthcare Research and Quality, 2006). Despite this, scientists continue to strive for a deeper understanding of the neurobiological factors that contribute to anorexia. Brain imaging scans and identical twin testing has helped advance medical understanding of the genetic and neurological aspects associated with anorexia (Anorexia Nervosa and Associated Disorders, 2014). Results from this particular line of research have raised further questions, leading therapists to consider the possible genetic risks and cognitive impairments that may be present in patients with anorexia.

**Genetics.** Research studies that analyzed the genetic makeup of fraternal and identical twins have revealed that genes can play a significant role in the onset of anorexia (American Psychiatric Association, 2000). Further research using systematic case-control studies has shown that having a relative with anorexia increases an individual's likelihood of later obtaining the disorder by twelve times compared to those with no familial genetic history (Duvvuri & Kaye, 2009; Engel, Staats & Dombreck, 2007). Gene testing of individuals with and without anorexia, has suggested that particular genes may be accountable for creating more vulnerable



temperamental features, increasing one's chance of becoming diagnosed later in life. Individuals who demonstrate increased levels of inhibition, restraint, and conformity have been shown to be more susceptible to developing restrictive eating behaviors (Duvvuri & Kaye, 2009).

**Personality traits.** Case study accounts overwhelmingly report anorexic individuals who demonstrate heightened levels of perfectionism, hyperactivity and a need for control (Brumberg, 1988; Bruch, 1973; Sue et al., 2010). Bruch (1973) believes that the individual possesses these personality traits prior to the disorder, and that other precipitating events (socio-cultural/developmental) lead them to restrict food. Bruch states, that the "drive for achievement often precedes the whole syndrome. The non-eating and the fear of being fat are resorted to after previous effort at establishing a sense of being in control have failed" (1973, p. 275).

Understanding how genetic composition and personality traits may influence one's vulnerability to acquiring an eating disorder may promote more proactive treatment in the future. This knowledge will enable social workers and medical professionals to identify and support high risk clients before disordered eating habits may take hold.

**Cognitive aspects.** The failure of current treatments has been exacerbated by anorexic patients' proclivity to deny the existence of their illness, their resistance to interventions, and their tendency to attribute emaciation to personal achievement and strength (Sue et al., 2010). Statistics suggest that only 33% of those struggling with anorexia nervosa are currently in treatment (National Institute of Mental Health, 2014). Some patients go as far as to idealize the disorder as a part of themselves by becoming involved with "pro-ana" and "thin-spiration" websites that supply tricks and support for individuals living with the disorder (Sue et al., 2010). Despite their physical appearance, many patients "vigorously defend their often gruesome emaciation as not being too thin, actively maintain it, and deny abnormality" (Bruch, 1978, p.

209). The cognitive distortions of the patient, centered on weight and achievement, have lead scientists to dig deeper into brain function with the hope of exposing a possible neurological explanation for continuation of the disorder.

Walter Kaye, director of The Eating Disorders Program at the University of California, suggests that individuals with eating disorders demonstrate brain functioning different than that of women of normal weight (Rosen, 2013). Work by Kaye and his colleagues has helped to suggest that anorexics may have a higher pain tolerance threshold (ignoring hunger pain) and an overactive prefrontal cortex, the "self-control center" of the brain. Kaye's research hypothesizes that over activation of this frontal cortex may be the culprit behind an anorexic's ability to deny the natural impulse to eat (Rosen, 2013). Despite brain scan differences found between anorexics and women of normal weight, Kaye's research is still unable to "prove" a cause and effect relationship. Rosen, reviewing Kaye's research (2013), writes, "years of psychological and behavioral research have helped scientists better understand some signs and triggers of anorexia but that knowledge hasn't straightened out the disorder's tangled roots, or pointed scientists to a therapy that works for everyone" (p. 2).

Duvvuri and Kaye, doctors also interested in the neurobiological aspects of anorexia, suggest that eating disorder onset is heightened by the chemical changes that occur during adolescent development (Duvvuri & Kaye, 2009). Their research has found dopamine and serotonin disturbances in young anorexics, suggesting that these chemical differences may place them at higher risk for developing an eating disorder (Duvvuri & Kaye, 2009). Heightened levels of serotonin, commonly found in anorexics, have been associated with increased anxiety. Additionally, disturbances in dopamine levels, also found in anorexic patients, have been associated with a lack of inhibition, repetition of behaviors, and hyperactivity (Engel, Staats, &

Dombeck, 2007). Duvvuri and Kaye (2009) suggest that an increase in anxiety in collaboration with a lack of inhibition is what causes anorexics to resort to food restriction as a means to reduce their "anxious mood" (p. 457). The pattern of food restriction and weight loss could be further explained by the dopamine "disturbances" effect on the patient's inability to feel achievement with weight loss. Researchers Engel, Staats, & Dombreck (2007) suggest that "improper levels of dopamine may explain why anorexics feel intensely driven to lose weight yet feel little pleasure in shedding pounds" (p. 1).

Duvurri and Kaye suggest that, once individuals develop anorexia, they enter into a "vicious cycle" of distorted brain functioning that is both created and perpetuated by self-starvation. They state, "Starvation and emaciation have profound effects on the functioning of the brain and other organ systems. They cause neurobiological disturbances that could exaggerate pre-morbid traits, adding symptoms that maintain or accelerate the disease process" (Duvvuri & Kaye, 2009).

In spite of the level of interest and attention being paid to neurobiological explanation for anorexia, progress has been slow and has failed to offer therapeutic solutions for social work practice. Clinicians' exposure to current empirical data is an invaluable tool. However, much of the brain chemistry data remains inconclusive and has created further medical debate. Genetic and neurobiological explanations need more empirical evidence to advance future practice at this time.

## **Social - Cultural Factors**

Social - cultural factors have been one of the leading explanations used to conceptualize the "anorexia epidemic." This etiology attributes the rise in diagnosis to the country's cultural emphasis on the feminine figure and the representation of medically underweight celebrities in popular culture. Joan Brumberg (1988), author of *Fasting Girls*, feels that, "the modern visual media (television, films, video, magazines, and particularly advertising) fuel the preoccupation with female thinness and serve as the primary stimulus for anorexia nervosa. Female socialization, in the hands of the modern media, emphasizes external qualities ('good looks') above all else" (p. 33).

Research suggests that 40-50% of women from westernized societies express dissatisfaction with their bodies (Bearman, Presnell, & Marinez & Stice, 2006; Monteath & McCabe, 1997) and that 50% of girls between the ages of 11-13 see themselves as overweight (Department of Mental Health, South Carolina, Eating Disorder Statistics, 2013). In a national U.S. survey, 47% of girls in 5th-12th grade reported wanting to lose weight because of magazine images, and 69% reported that magazine pictures had influenced what they perceived to be the ideal body type (Levine, 1998 as cited by National Association of Anorexia Nervosa and Associated Disorders, 2014). To add insult to injury, studies suggest that the body weight and shape of females portrayed in the mass media are naturally possessed by only 5% of American women. This creates a cultural standard that is not representative of the average female body type (National Association of Anorexia Nervosa and Associated Disorders, 2014).

**Pro-Ana Culture.** In collaboration with the inaccurate media portrayal of female body type ideals, pro-anorexia websites have created an online sub-culture that helps support and promote eating disordered behaviors (Sue et al., 2010). These websites offer tips on restricting

caloric intake and idealize emaciated celebrity figures, speculated to have their own eating disorders (Sue et al., 2010). Sue et al., (2010) write, "Such websites are visited by thousands of people each day and used frequently by adolescents with eating disorders who reported learning new weight loss and purging methods. Medical experts are deeply concerned that the sites will produce a surge in eating-disorder cases, especially among susceptible individuals" (p. 208).

In response to these and other overwhelming statistics that support the influence of social media on body image, The American Psychological Association publicly stated that "the media [plays] a prominent role in the development of body dissatisfaction" (Ferguson, Winegard & Winegard, 2011). Social theorists draw upon these findings to suggest that the overwhelming emphasis placed on dieting and beauty has created a standard that has increased the prevalence of current anorexia diagnoses (Garner, Garfinkel, Schwartz, & Thompson, 1980). Gordon (1990), a theorist supporting this perspective, goes as far as to suggest that anorexia has become a "culture-bound syndrome" describing it as a core cultural conflict that is more pervasive for westernized women.

A longitudinal study conducted by Garner et al., (1980) looked to assess the truth behind the social emphasis on the female "thin ideal" in sexualized media content by comparing the body measurements of female Playboy centerfolds over the course of twenty years. Centerfold body weight was measured and compared using waist to bust ratios. Results of the study showed a significant increase in overall model thinness, with a measureable decrease in waist to bust ratios from 1959-1979 (a time when anorexia diagnosis was reaching a peak in modern culture).

Owen & Larel-Seller (2000) drew on the Garner et al. (1980) study by examining the calculated Body Mass Index scales of centerfold models from 1985-1997. Their study utilized Body Mass Index (BMI) scales instead of Garner's (1980) waist to bust ratios after doctors

argued that BMI scales were a more accurate measure of body fat content (Stensland & Margolis, 1990). Body Mass Index scales are calculated by dividing an individual's weight (in kilograms) by their height (in meters squared). A healthy BMI score is classified as one that falls between a calculated score of 20-25. Individuals that compute above or below these measurements are considered to be over or under body fat expectancy for their height and weight range (Williamson, 1990). One of the DSM's main criteria for diagnosable anorexia is the maintenance of a body weight less than 85% of what is expected for an individual's age and height. This translates to a calculated Body Mass Scale that falls below 17.5. BMI calculations have been used as a universal measure for doctors to identify the level of emaciation present in the anorexic patient (American Psychiatric Association, 2000). The sample reviewed for Owen & Larel-Seller's (2000) study was composed of 157 Playboy magazine centerfolds selected from issues published between the dates of 1985-1997. The results showed that the more recent models were taller than in earlier decades, but maintained the same weight average as the years prior. Since BMI is calculated through the division of one's weight by height, an increased height resulted in lower BMI scales. Owen & Larel-Seller (2000) confirmed the unhealthy weight of females represented in sexualized media content. Their study went on to discover that 99% of the sample size was considered medically underweight, and nearly 50% met diagnostic criteria for anorexia nervosa. The Owen & Larel-Seller (2000) and Garner et al. (1980) studies both confirmed the theory that the media continues to portray models with decreasing waist lines, leading social theorists to identify these images as key perpetrators for eating disordered behaviors.

Attributing socio-cultural influence to the development of anorexia can help explain the disproportionate number of diagnoses found in westernized cultures. It can also offer a possible

explanation for the gender inequality in diagnoses, with female cases disproportionately outweighing males (Brumberg, 1988). However, this etiological factor does not explain the existence and documentation of restrictive eating behaviors dating back to as early as the 1870s, long before mass media had taken hold of society (Brumberg 1988). While it is crucial to understand the aspects of society that enhance and perpetuate eating disordered behaviors, this etiology lacks the ability to supply solutions or inform useful treatment techniques. It also places unnecessary blame on the victim, suggesting that women are at fault for being effected by unrealistic cultural standards.

Genetic risk factors, biological predispositions, and social pressures have all been proposed as contributing factors for the development of anorexia nervosa. These aspects are all important in understanding the multifaceted components that may lead to the disorder. While it is important to understand these contributing factors, full conceptualization of anorexia would not be complete without examining the important developmental and familial components that have been identified as possible cultivators of eating disordered behaviors. The following will outline the developmental and familial explanations for anorexia nervosa.

### **Individual Developmental Factors**

One of the initial explanations for anorexia stemmed from Freud's conceptualization of the five psychosexual stages of development. This viewpoint suggested that oral fixation, involved with disordered eating patterns, was a result of the "organism's failure to master sexual excitation" (Bruch, 1973, p. 216). Psychoanalysts from this view point associated induced vomiting and food restriction to deeper sexual conflicts that had been internalized by the patient. Explanation for prolonged starvation focused on the patient's unmet desire to mother a child (Bruch, 1973). Doctors that supported this theory suggested that the symptoms that resulted

from emaciation (bloated stomach, loss of menstruation) were meant to replicate pregnancy and demonstrated the patient's subconscious desire to conceive a child with her father (Bruch, 1973). This theory is dated and unable to be scientifically supported. This misapplication of Freudian theory holds little relevancy in current treatment.

**Maternal connection & feeding anxieties.** Alternative developmental understanding of anorexia has focused on the initial experiences of the patient, attributing the source of disordered eating to less than adequate primary feeding experiences. Early psychoanalytic explanation for food refusal placed blame on the mother, suggesting that she had failed to provide a nurturing environment while breast feeding her infant daughter. Bruch (1973) states, "The nursing experience often appears to be a nexus of trauma, confusion, rejection, and frustration, a precursor of subsequent open conflicts. The expected outcome of a mother's overprotective attitude, namely excessive dependency, unquestioning obedience, and a wilted kind of passivity, materializes early in many anorexic patients" (p. 56). Mothers who were unable to meet the early nutritional demands of the child, while simultaneously relieving the child's anxieties around the feeding process, were deemed the source of the patient's later eating issues (Bruch, 1973).

**Attachment styles.** Early attachment styles have also been examined as a possible explanation for the onset of anorexia. Limited research has suggested that individuals who develop anorexia may demonstrate higher levels of insecure attachment patterns. These patterns of behavior were initially observed and classified through the "Strange Situation Study" conducted by Ainsworth and Bell (1970). The study asked mothers to quietly leave the room, while the child (8-12 months of age) was left to play. Ainsworth and Bell (1970) observed the child's behavior both when the mother left, and when she returned a few moments later.



Ainsworth and Bell (1970) concluded that there were two types of insecure attachment styles. The first style was insecure-avoidant, in which the child is not attached or dependent on the mother, and shows high levels of independence. This style of insecure attachment often stems from a mother who has been unresponsive or dismissive during times of emotional distress (Ainsworth and Bell, 1970). The second type of insecure attachment is insecure-ambivalent. This style is often demonstrated through an overly clingy child who is easily distressed. Insecure-ambivalent children are often unable to be soothed, even when given attention by their mothers (Berzoff, Flanagan, & Hertz, 2011; McLeod, 2011). This style of insecure attachment is often the result of inconsistent responses from the primary caregivers, resulting in the child's inability to establish a sense of security in both their presence and absence (McLeod, 2008).

These attachment styles were thought to be cemented within the first 12 months of development as a way for the child to decrease anxiety stemming from the mothers' inability to respond to primary needs (Berzoff et al., 2011). Initial forms of attachment were thought to create "internal templates or schemas of interactions, defining the expectations of infant and young child for what close relationships are like" (p. 193). A study conducted on 27 inpatient participants with eating disorders using the Separation Anxiety Test showed that 96% of participants demonstrated insecure attachment styles. These findings suggest that individuals with anorexia may have attachment impairments, both insecure-avoidant and insecure-ambivalent, that may have stemmed from early childhood experiences and their mothers' inability to respond to primary needs (Armstrong & Roth, 1989).

Researcher Cathy Orzolek-Kronner (2002) wanted to expand on these findings by examining Bowlby's "proximity seeking behaviors" in patients with eating disorders. Bowlby's (1969, 1973, 1980) conceptualization of proximity seeking behaviors were classified into five

actions that occur in early infancy. The behaviors he observed included, sucking, crying, smiling, clinging, and following. These initial aspects helped to form and solidify an infant's security with their primary care givers (Bowlby 1969, 1973, 1980).

According to the observations of Orzolek-Kronner (2002), the common response that manifested from a child's food restriction was an increased level of closeness and attention from the mother. Her theory was further supported through the numerous self-reports of mothers' stating that they knew much more about their daughters after recovery and that the issues exposed by the disorder had led to a deeper relationship (Orzolek-Kronner, 2002). Orzolek-Kronner took these observations and suggested that eating disorders were an attempt at repairing an attachment deficit that had occurred in early development. Orzolek-Kronner (2002) writes, "It seems that the close physical proximity that results from the feeding experience between infants and their mothers is re-enacted through the anorexic's refusal to eat and the myriad of feeding efforts many mothers will attempt to ameliorate this situation" (p. 422). Orzolek-Kronner (2002) suggests that inadequate early bonding and attachment between mother and daughter caused the patient to regress to early ways of relating. By restricting food the child unconsciously reinstates the early feeding process, fostering closeness and connection between both parties.

Orzolek-Kronner's study measured three sub-groups of participants (those clinically diagnosed with an eating disorder, those with other diagnostic disorders, and those with no current psychiatric diagnosis). All three sub-groups were given Inventory of Parent and Peer Attachment, a measure developed to assess the perceived level of support and "psychological security" family members and friends offered the patient. Patients were also given Proximity

Seeking Scales, designed by the author of the study to measure "the degree of both physical and psychological closeness between the child and her parents" (Orzolek-Kronner, 2002).

Results showed that the eating disorder and clinical groups saw their mothers as less supportive than those of the non-clinical sample. This confirmed Orzolek-Kronner's (2002) theory that individuals suffering from psychological disorders tend to demonstrate insecure attachment patterns. Of additional importance, the eating disorder group reported higher levels of proximity seeking behaviors than their clinical and non-clinical counterparts, suggesting that eating disorders do perhaps work as a way for the child to attempt to obtain more closeness to their mothers by repeating early feeding patterns (Orzolek-Kronner, 2002).

Orzolek-Kronner's (2002) findings support the speculation that the anorexic patient has failed to achieve independence, suggesting that the patient desires closer contact and connection with their primary caregivers (Bruch, 1973, 1978; Minuchin, Rossman, & Baker, 1978). Orzolek-Kronner argues that individuation and separation cannot occur without the individual first creating secure attachments with their caregivers, suggesting that eating disorder symptoms work as an attempt at a reparative function to mend initial unsuccessful attachment between the patient and mother (Orzolek-Kronner, 2002).

It is important to note that this study contains limitations and that the findings should be considered with these in mind. While Orzolek-Kronner's study suggests a possible alternative explanation for eating disorder etiology, its results rely on the self-report of mothers, and a rating scale created by the researcher herself. Further testing and validation needs to occur for these findings to be strengthened and implemented into practice. Despite limitations in the efficacy of the study's findings, Orzolek-Kronner (2002) offers an interesting proposal that eating disorders work as a reparative function fueled by the individual's deeper desire for maternal closeness.

## Self-Psychology Theory

Self-psychologists suggest that anorexia stems from less than adequate relationships with primary caregivers (Bachar, 1998; Bruch, 1978; Geist, 1989; Williams & Reid, 2012). This developmental theory attempts to understand anorexia through the lens of self-psychology, identifying the disorder as one manifestation of the failure to form a cohesive self (Kohut & Wolf, 1978). Kohut and Wolfe (1978) describe the cohesive self as "the center of the individual's psychological universe. It is what we refer to when we say "I feel" such and such, "I do" such and such. The healthy human self is experienced as a sense of wholeness, aliveness, and vigor, an independent center of initiative over time and through space. This is the essence of one's psychological being" (Geist, p. 149). The foundation for this theory stems from Heinz Kohut's work on the disorders of the self and the long-term effects that can occur when initial caregivers are not able to provide an adequate environment for their child.

Mental health professionals who utilize this theory suggest that children raised in less than adequate empathic environments are unable to develop a cohesive self. Geist (1989) argues that, "When a child feels understood, he/she experiences a sense of realness - an awareness of being alive, personally present, and invested in one's own functioning, activities, and capacities. Empathy, by its mere existence, becomes sustenance that, as Kohut (1980) suggests, keeps the self psychologically alive" ( p. 3). Self-psychologists believe that individuals who lack a cohesive self later develop a "fear of psychic emptiness, loss of creative living, and fragmentation, resulting in psychological depletion, loss of vitality, and threat to self-cohesion" (Geist, 1989). This deficiency in early development inhibits individuals from fostering independence, confidence, and autonomy throughout the trials and tribulations of later life. The

absence of this primary developmental achievement is what self-psychologists have suggested is associated with later onset of anorexia.

Self-psychology based theorists suggest that food works as a way for the anorexic patient to manage inner feelings of emptiness by controlling the amount of food in their stomachs. Bachar (1998) explains, "The eating-disordered patient organizes some control over the fear of emptiness by creating 'controlled emptiness' by vomiting or avoiding food" (Bachar, p. 151). Williams & Reid (2012) and others elaborated upon this, theorizing that the disordered eating behaviors "offer people a sense of control over food and their bodies, which they feel they do not have in any other aspects of their lives and this control can help them build their sense of self" (Dignon, Beardsmore, Spain & Kuan, 2006; Malson, 1998; Reid, Burr, Williams & Hammersely, 2008). Empirical studies grounded in this theory have concluded that anorexia provides patients with feelings of "guardianship, reliability, and protection as well as an increased sense of self-confidence, feelings of control and a method of communicating emotion" (Williams & Reid, p. 799). For this reason it can be difficult for therapists to maintain empathy with patients with more severe forms of the disorder, as their maladaptive behaviors reinforce feelings of pride, entitlement and achievement. Addressing and removing ego-enhancing behaviors can be frustrating, tedious and often times unsuccessful.

Understanding the early developmental deficiencies, often present in the anorexic patient, could supply a more effective treatment framework for therapist and treatment teams. Anorexic patients' resistance to treatment has been theorized to stem from doubt in the therapist's ability to empathize or relate to their issues. If treatment teams enter into therapy utilizing Kohut's theoretical lens of self-psychology, they may be better prepared to avoid impasses in treatment success by understanding how to connect with and support the patient. Bachar (1998) suggests

that practice, based upon this theory, is more likely to be productive in application to the treatment of anorexia than with other psychological disorders. She argues that anorexics are rarely understood and "Interpretation for these patients can be experienced, especially at the beginning of therapy, as imposing something from without" thus damaging the necessary rapport to achieve successful recovery (p. 148). Bachar (1998) writes "The patient in therapy with a self-psychologically oriented therapist feels that the therapist maintains an attuned stance rather than an adversarial one. The patient experiences the therapist's neutrality as benign; and that the therapist is effectively on the side of the patient's self without necessarily joining the patient in all of his/her judgments. The therapist, according to Kohut, sees him/herself as being simultaneously merged with, and separated from, the patient" (p. 148).

### **Limitations with Self-Psychology Theory**

Issues with this theory lie in its inability to take into account contributing external factors, present in the individual's life, when onset occurs. Studies suggest that 95% of cases occur between the ages of 15-24 (Department of Mental Health South Carolina, Eating Disorder Statistics, 2013), suggesting that familial and developmental factors play a key role in onset. Another weakness in using self-psychology is the lack of empirical support currently available on the success of practices with anorexic patients based upon this theory.

## **Family Systems Theory**

Therapeutic practice based on family system theory has been shown to be the most effective at treating patients whose anorexia onset occurs in early adolescence, a time when the family is still very much involved in the patient's life (Eisler et al., 2007; Lock & Le Grange, 2001; Robinson et al., 2012; Steinhausen, 2002). This approach to treatment helps the clinician identify patterns in the patient's family environment in order to change maladaptive responses to stressful situations. Treatment based upon this theory utilizes the strength of the family unit for the benefit of the patient's recovery (Eisler et al., 2007; Lock & Le Grange, 2001; Robinson et al., 2012; Steinhausen, 2002).

Structural family theory, initially founded by Salvador Minuchin, focused on the symptoms of an individual being the direct result of the family's relational patterns (Minuchin et al., 1978). This theory later influenced Bowen's development of a family systems theory, which carried the belief that the alleviation of symptoms on the individual level could and would not occur until changes to the overall family structure was achieved (Goldenberg & Goldenberg, 2013). Family therapy practices currently place strong emphasis on the therapist's role in leading the family to a more effective and adaptive way of functioning (Goldenberg & Goldenberg, 2013). Aspects of Minuchin and Bowen's family theories have been used as an attempt to better understand the familial factors that may contribute to the onset of anorexia in order to assist and promote long-term recovery (Eisler et al., 2007; Lock & Le Grange, 2001; Robinson et al., 2012; Steinhausen, 2002).

## **Limitations of Family Systems Informed Practice**

Limitations in utilizing a family systems approach on its own lie in its inability to translate to patients whose onset occurs in later development, and those whose families are unavailable to participate in treatment. While it is important to understand the ways that families can influence an individual's current functioning, a family systems approach fails to provide therapists with a framework in treating patients with later-onset anorexia or more prolonged episodes of eating disordered behaviors.

## **Treatment Options**

There are a number of treatment options available for anorexia nervosa. These interventions may include inpatient hospital stays along with outpatient psychotherapy depending on the degree of emaciation and observed health risks of the individual (Sue et al., 2010). Self-psychology and Family Systems Theory as well as any other theoretical framework can inform a range of treatment options. Treatment of anorexia nervosa may at different times use many theories in addition to those chosen for this theoretical exploration. Due to the nature of the illness and the cognitive effects starvation has on the body, weight restoration is always the first goal of treatment. This process must occur before psycho-therapy can become successful at addressing the underlying psychological aspects of the disorder. Interventions at this stage can be difficult, cause extreme fear in the patient, and involve the need for collaboration on the part of physicians, psychiatrists, and psychotherapists (Sue et al., 2010). Weight restoration is often slow with successful increases measured at 1-3 pounds per week (National Association of Anorexia Nervosa and Associated Disorders, 2014).



Once the patient has been restored to a minimum healthy weight, a number of therapy options are available to treat anorexia nervosa's psychological and cognitive aspects. Anti-depressants may be introduced to patients that have co-morbid diagnoses such as anxiety and/or depression along with anorexia. However, studies have shown that these pharmacological interventions are no more successful at preventing relapse than placebo drugs (National Association of Mental Illness, 2014).

### **Cognitive Behavioral Therapy**

Cognitive Behavioral Therapy (CBT) has been adapted to treat a range of eating disorders by focusing on addressing the distorted "cognition" of the patient. CBT helps patients identify negative thinking patterns by challenging them with more positive and rational thoughts (Cowden, 2013). Treatment is dedicated to encouraging the patient to identify individual self-worth with other aspects besides body weight, shape, and size (Cowden, 2013). Therapy sessions that utilize the CBT framework involve homework assignments (often food diaries) used to help the patient identify and challenge the thoughts that coincide with their restrictive eating, or purging behaviors.

CBT has been implemented in both inpatient and outpatient treatment settings for eating disorders. While it has shown to be effective in challenging eating disordered patterns, studies have often focused on adult anorexia and have not been widely utilized in adolescent cases (the most prevalent). This is because this modality is hard to implement with patients who are unwilling to complete homework assignments, are unwilling to address emaciation, and who have shown previous resistance to treatment. Individuals that seek CBT treatment must be willing participants in their therapy, something that is less common in this disorder, and particularly less common in early adolescence development (Cowden, 2013).

## **Dialectical Behavioral Therapy**

Dialectic behavioral therapy (DBT) was developed in the 1970s by Marsha Linehan. This therapeutic approach was adapted from both cognitive behavioral techniques and eastern mindfulness practices. The approach uses four skills: interpersonal effectiveness, emotional regulation, distress tolerance, and mindfulness. These four components are implemented to promote more effective coping skills in the individual (Vivo, 2014). DBT focuses on helping patients identify triggers for their disordered eating behaviors and tries to help them find other ways of responding to these stressors. Therapists work with patients to reframe the way they think about food by teaching mindful eating habits and focusing on the emotional responses patients have to food (Vivo, 2014).

Research suggests that DBT has been successful at helping patients "combat guilt, shame, and other self-defeating emotions, [by encouraging] people to recognize and accept their feelings without judging them as good or bad or acting out behaviorally" (Vivo, 2014). Studies have found efficacy in using this treatment for eating disorders. However most of the success has been found in treatment of bulimia and binge eating disorders, suggesting it may be hard to apply to the specified treatment of anorexia nervosa (Vivo, 2014).

## **Maudsley Family Model**

The Maudsley Family Model is the most empirically supported approach for treating individuals with anorexia that occurs in adolescence. This model is used with individuals who have symptoms that have presented within less than three years, who are still in a stage of development (adolescence) where they are living at home, and the family is highly involved. This framework is based upon the previously mentioned family systems theories, and involves

dedication and effort on the part of both the patient and their immediate family. This framework works in three phases: weight restoration, returning control to the adolescent, and establishing a healthy adolescent identity (Lock & Le Grange, 2013). The Maudsley Model is a more structured form of therapy that is based on the idea that the family has the solutions to support and assist the adolescent through the treatment process.

Two potential obstacles have been identified by researchers when entering family based treatments: fear of action/fear of inaction. Hinderbrandt et al., (2012) evaluated the way the family's and individual's internalized fears of treatment may have inhibited its success. The study found that there was often an overwhelming presence of guilt and feelings of blame present in both anorexic patients and families. This study is important as it emphasizes the need for therapists to be well versed in a family therapy model and to be comfortable identifying patterns that may be inhibiting treatment from moving forward.

The Maudsley Model has been found to successfully prevent expensive hospitalization "by assisting parents in their efforts to help their adolescent in his/her recovery from AN, and to return him/her to normal adolescent development unencumbered by the eating disorder" (Lock & Le Grange, 2013). While this treatment model has been supported in a number of trials, (Eisler, Dare, Rhodes, Russell, Dodge & Le Grange, 2000) the program's format requires the therapist to be able to navigate the diversity of family dynamics while simultaneously eliminating feelings of shame and guilt. If the therapist is not well-versed in a family systems theory, their inability to identify common themes and behaviors may inhibit them from successfully guiding the family through the Maudsley Model approach.

By gaining a deeper understanding of family systems theory therapists may be able to better identify the trends that exist within the family organization and relational patterns of

anorexic patients. The recognition of such factors could provide families with insight that could relieve harsh judgment, enabling them to become more supportive to the patient, and possess the ability to engage in the Maudsley approach to treatment. These clinical approaches could contribute to an increase in long-term recovery rates for anorexic diagnosis.

### **Conclusion**

In conclusion, anorexia, as a medical and psychological disorder, continues to be a perplexing, complicated, and demanding reality for our "thin obsessed" society. This chapter has outlined some of the various factors that have been found to influence the development of anorexia. However, factors identified as causal may have also created room for clinical error and vast difference between therapeutic practices. Over a century of less than successful treatment and the lack of any pharmacological cure suggest that universalized treatment techniques may not work on this complex disorder.

The following chapter will present an outline of Kohut's self-psychology theory and discuss the research related to diagnosis and treatment of anorexia through this theoretical lens. By utilizing ideas from family systems theory in collaboration with Kohut's self-psychology perspective, therapists may be better equipped to conceptualize the multi-faceted dynamics that could be creating and perpetuating eating disordered behaviors. This dualistic approach to treatment may provide a therapeutic climate that is able to address the more pervasive self-esteem issues and body image distortions that linger long after weight is restored, while also remediating the effects of some suggested causal factors by fostering the support of the patient's family system.

## **CHAPTER IV**

### **SELF-PSYCHOLOGY**

#### **Historical Development of Self-Psychology**

Heinz Kohut (1971, 1977, 1984) was a Freudian analyst and the primary developer of self-psychology. Kohut's work began as a deconstruction of Freud's drive theory, giving shape to what is now considered to be a core theoretical framework. His work has significantly affected psychoanalytic understanding of early development, and now offers an alternative way to conceptualize and treat individuals with disorders of the self (Berzoff et al., 2011). Kohut's original work was largely controversial at the time of publication, as it contradicted and discredited psychoanalytic understanding of human development. Kohut strayed from Freud's initial credence that pathology resulted from unresolved internal sexual and aggressive drives. He instead underscored the importance of fostering infantile feelings of belonging and acceptance, identifying the degree to which these needs were met, as the core predictor of later psychological health (Banai, Mikulincer & Philips, 2005).

#### **Observations in Therapy**

Kohut's theory of self-psychology was originally developed to better conceptualize and treat individuals with narcissistic personality disorders. Kohut (1972) identified that regular psychoanalysis was not working with these patients, observing that therapeutic interpretation

caused the patient to retreat further into neurosis. He wrote, "These patients initially create the impression of a classical neurosis. When their apparent psychopathology is approached by interpretation, however, the immediate result is nearly catastrophic" (p. 625-626). Kohut proposed that psychological conflict worked as a way for these patients to protect themselves from the more impending threat of "the breakup of the self" (Mollon, 2002). He observed that these patients used him as a temporary external object, existing in order to fill a personal need. Kohut coined the term "self-object" suggesting that narcissistic patients perceived him not as a person but as an object that supplied a need they could not provide for themselves.

### **The "Self-Object" Defined**

Kohut (1978) believed that self-objects were "objects which we experience as part of our self." He understood that these objects were necessary for the development of a cohesive self and that they were provided for through early relationships with primary caregivers (Kohut & Wolfe, 1978 p. 414). Kohut originally distinguished two types of self-objects necessary for optimal development. He wrote, "There are two kinds of self-objects: those who respond to and confirm the child's innate sense of vigor, greatness and perfection; and those to whom the child can look up and with whom he can merge as an image of calmness, infallibility and omnipotence" (Kohut & Wolfe, 1978, p. 414). Kohut believed that an individual's primary caregivers worked as initial self-objects and that their actions in response to the child's innate narcissistic demands would either firm up or fragment the child's self over time. While self-objects were often people, individuals could also develop self-objects that were represented in places or things. Berzoff et al., (2011) explain "Self-psychology theory postulates that self-objects, understood as people or things outside of the self, are vitally necessary to every individual as sources of mirroring, as sources of perfection and grandeur to merge with, and as

similar selves to feel at one with. Self-objects are needed to fulfill these functions throughout the life cycle and are called self-objects because they stand not as objects to be related to in and of themselves but as objects that function to give the self what it needs in order to become and remain energetic and cohesive” (p. 168). Kohut believed that these self-objects not only provided the child with later psychological stability but also worked to create the child’s individual identity. Psychologists Greenberg and Mitchell (1983) state, "For Kohut the child is born into an empathic, responsive human milieu; relatedness with others is as essential for his psychological survival as oxygen is for his physical survival" (p. 353). Kohut held that all individuals possessed the need and desire to develop these initial self-object relationships and felt that the psyche of a child was highly influenced by a caregiver’s ability to provide them (Banai et al., 2005). Failure to meet early self-object needs could become problematic as the child would lack the ability to view the self-object as an entity in itself, possessing its own needs and desires.

### **The "Self" Defined**

When conceptualizing self-psychology it is important to understand Kohut's use of the word "self" as defined as the "center of the individual's psychological universe"(Hoyt, 2011). Kohut distinguished the "self" as separate from individual identity, suggesting that the "self" was "the core of the personality made up of various constituents in the interplay of the child's earliest self-objects" (Ornstein, 1990). Kohut (1977) believed that a child was born without a sense of self and that over time the interactions with primary caregivers would either "firm" or "fragment" the child's “self” structure. Kohut held that individual self-esteem fell on a continuum and could fluctuate due to individual failures or accomplishments (Mitchell & Black, 1995). Individual's

that had developed a firm self were able to experience let downs without fragmenting their own internal psychic structure (Ornstein, 1990).

### **Developmental Axes: Grandiosity, Idealization, Alter-ego Connectedness**

Kohut held that the formation of a cohesive self was dependent on the normal development of three "connected dimensions" (Banai et al., 2005). The three axial needs of early infancy are provided by interpersonal relationships (often with the mother). These primary needs are a combination of the individual's subjective interpretation of themselves and the environment's response to her demands (Banai et al., 2005). The three axes supply an individual with a "sense that all features of one's personality (are) facets of a single, well integrated structure," allowing her to maintain strong goals and a healthy self-esteem in the face of disappointment (Banai, et al., p. 225). The first axis, grandiosity, refers to the child's need to be praised and admired, solidifying feelings of greatness and accomplishment. When adequately provided, it results in a person with "self-worth, healthy ambition, commitment, assertiveness, and accomplishment" (Kohut, 1971 p. 225). The second axis, idealization, refers to the development of a person's ability to identify and achieve personal goals. This axis requires the caregiver to promote an environment that pushes the child to achieve realistic goals, while also providing the tools to manage minor failures. This axis allows the child to "merge" with the good qualities observed to be possessed by the caregiver. When developed normally this axis provides an individual with a strong set of beliefs, values, and personal standards (Banai et al., 2005). The third and final axis, alter ego-connectedness, refers to the child's development of interpersonal connections and the ability to express inner emotions. This axis requires the caregiver to promote feelings of similarity and belonging. The caregiver needs to strike a balance between the promotion of the child's innate individuality and the simultaneous fostering of feelings of



oneness and connection. When adequately provided for this axis represents the individual's overall feelings of acceptance and belonging (Hoyt, 2011).

### **Self-object Needs: Mirroring, Idealization, and Twinship:**

In addition to the developmental axes demands, Kohut identified three self-object needs that were necessary in order to solidify a cohesive self. The first self-object need was mirroring. This refers to a child's need to be praised for her accomplishments and made to feel special.

When this self-object need is satisfied, it promotes feelings of pride in individual accomplishments. This self-object need is often met along the grandiosity axis. (Kohut, 1971).

The second self-object need is idealization. This refers to a child's primary need to admire one of her caregivers. The child needs to view the parent as omnipotent, while also feeling the ability to merge and identify with the parent's strengths. Satisfaction of this self-object need occurs along the idealization axis and produces an individual's later ability to feel confident, set realistic goals, and move through the world with a sense of security. The final self-object need is twinship, which refers to a child's need to feel similar to a significant other and occurs along the alter-ego connectedness axes. Kohut & Wolf (1978) felt that children need a parent they can relate to interpersonally (often of the same sex) who can foster lasting feelings of belonging, empathy, and connection.

Kohut held that if these three self-object needs were met an individual's need for self-objects would diminish over time. Banai et al., (2005) writes, "Caregivers' empathic responses to children's narcissistic needs foster the development of an inner state of stability, security, and self-cohesion" (p. 277). On the other hand, consolidation of this sense of self-cohesion makes self-objects less necessary because the individual's own cohesive self becomes the major agent of self-regulation. That is, with satisfaction of self-object needs, a person's feelings of healthy

grandiosity, idealization, and connectedness are strengthened, and he or she gradually acquires self-regulatory capacities" (p. 227).

### **Optimal Frustration & Transmuting Internalization**

Kohut believed that there were two final and imperative components to the development of the self; they are optimal frustration and transmuting internalization. Optimal frustration is the process that Kohut identified as occurring through the thousands of interactions between a child and her primary self-objects. Optimal frustration explains the failure on part of the self-object to consistently meet a child's needs (Kohut & Wolf, 1978). This experience of frustration helps the child strike a balance between self-indulgence and deprivation. Examples of non-traumatic, frustrating failures include denying a child's unrealistic requests, or temporarily avoiding them while preoccupied with another task. Kohut believed that such events were inevitable and that these minor failures would solidify a child's later sense of boundaries. Hoyt (2011) writes, "Optimal frustration becomes the basis of a sense of boundaries in later life: when a child repeatedly experiences a parent not responding to demands for immediate gratification or soothing, the child internalized that he must find inner sources to sooth and comfort himself" (p. 3). Kohut felt that these failures needed to be minor to be effective, and that individuals who experienced too much or too little frustration would develop maladaptive ways of comforting themselves in later life.

Transmuting internalization was a process that Kohut describes as the child's absorption of her self-object's idealized qualities and functions. A child reared in an environment successful at meeting axial and developmental needs, would gradually become less dependent on her primary self-objects. This process of transmuting internalization is the final step in "crystalizing" a

cohesive self and endowed the child with the ability to self-soothe in the absence of her self-objects (Kohut, 1978 & Wolf, 1978).

**Failure to form a cohesive self.** Kohut believed that the inability to develop any three of the core axes or to receive adequate self-object experiences results in an "underlying lack of self-cohesion, serious doubts about one's sense of continuity over time, lack of confidence in one's ability to deal with life's hardships and vulnerable self-esteem" (Kohut & Wolfe, 1978 p. 226). Individuals unable to form a cohesive self would become more vulnerable to external disappointments, ruminating on their failures and individual deficiencies (Banai et al., 2005).

### **Treating Disorders of the Self**

Kohut spoke in depth about the role of the therapist in treatment of individuals with narcissistic personality disorder. He observed that these patients would "reactivate the specific needs that had remained unresponded to by the specific faulty interactions between the nascent self and the self-objects of early life" (Kohut & Wolfe, 1978 p. 414). This observable behavior caused Kohut to suggest a different approach to therapy. He proposed the therapist becomes a primary self-object, and that the process of therapy allows for the replacement of the faulty interactions of early childhood with new and successful self-object experiences. The therapist's overarching goal of treatment is to assist the patient in the development of the psychological components she had failed to develop in early childhood.

Kohut identifies two core interactions imperative for the therapeutic treatment of narcissistic patients. The first is identified as mirror transference. This occurred through the patient's belief that the therapist is able to "accept and confirm" their current suffering. Mirror transference was stimulated by the therapist's ability to portray deep empathy while accepting the patient's manifesting behaviors without judgment. This transactional pattern provides the

patient with feelings of acceptance and validation (Kohut & Wolfe, 1978). The second requirement, idealization transference, refers to the patient's need to feel that the therapist is omnipotent, and that she possesses the strength and stability to soothe the patient in times of distress. This process provides the patient with the self-soothing capacities that her primary self-objects failed to provide. If the therapist is successful at mirroring the patient's suffering, while providing a sense of safety and omnipotence, the patient can successfully merge with the therapist strengths, taking her idealized qualities for herself.

### **Applying Treatment to Anorexic Patients**

Although Kohut's idea started as a way to better conceptualize and treat narcissistic patients, his theory has been used to explain a number of other complicated disorders. Berzoff et al., (2011) suggest that "Self-psychology is considered to be a useful clinical theory precisely because it is very open and positive in its view of human nature and because of its focus on the individual" (p. 161).

A number of articles have surfaced that suggest similarities between the vulnerabilities presented in the anorexic patient, and those in the narcissistic individual. Psychologists, Wassell-Kuriloff & Rappaport (1987) draw upon Kohut's theory of self-psychology by suggesting that denial of basic needs (food) paradoxically works as a way for the anorexic patient to protect herself from deeper impending threats of fragmentation. They highlight Kohut's conceptualization of self-objects to propose that food restriction results from inadequate infantile self-object relationships and the overall inability to successfully self-soothe.

Researcher Geist (1984) suggests that the anorexic patient's mistrust in others' ability to empathize and her resistance to therapeutic interventions are similar to the tendencies of a narcissist. Wassell-Kuriloff & Rappaport (1987) reference Geist's work stating "Geist (1989)

presents rich clinical examples of the narcissistic vulnerability of anorexic patients. He explains these individuals' use of the treatment relationship to buttress a shaky identity, and he stresses therapeutic empathy for their subjective feelings of selflessness, rather than the interpreting of behavior as objectively selfish, aggressive and/or infantile" (p. 97). Geist proposes that therapists treat anorexic patients through the lens of self-psychology. He feels this perspective could help therapists better empathize with the patient and avoid treatment resistance. By viewing an anorexic's actions as protective coping strategies the therapist could avoid the misinterpretation of symptoms as willful or selfish.

Through the lens of self-psychology mental health professionals may be able to gain a deeper understanding of the particular therapeutic needs of the anorexic patient. Unlike other disorders, anorexia has been misinterpreted as attention seeking and in the patient's control. Kohut's therapeutic outline suggests that a therapist's inability to understand these clients may increase feelings of isolation and self-hate, perpetuating the patient's desire to self-soothe through maladaptive means (food restriction).

Self-psychology suggests that the removal of an eating disorder patient's behaviors (self-starvation) before helping her develop a sense of "self" could result in imminent psychic fragmentation and therapeutic impasse. Mollon (2002) further explains this when he writes, "pathological structures or patterns of object-relating may be clung to because change may threaten fragmentation of the self" (p. 5). Self-psychology suggests that food restricting behaviors are deeper manifestations of "orality, dependency, and voracious, greedy impulses for immediate gratification" (Wassell-Kuriloff & Rappaport, 1987). This theory suggests that the patterns of behavior (calorie counting, food restriction, isolation) have become a way for the patient to temporarily silence and avoid early "insatiable needs." These patients often present as

falsely omnipotent, finding pride in their ability to deny basic nutritional demands. Premature removal of these self-employed defenses could threaten internal fragmentation by increasing feelings of dependency, guilt and shame (Wassell-Kuriloff & Rappaport, 1987).

### **Recommendations for Treatment**

In summary premature interpretation of anorexic patients' symptoms could perpetuate the maladaptive coping mechanisms their psyche has employed to protect them from fragmentation, i.e., self-starvation. By following Kohut's treatment of individuals with disorders of the self, therapist may be able to supply anorexic patients with the self-object needs they have been denied and deeply crave. Wassell-Kuriloff & Rappaport (1987) propose that the therapist work as a container for the patient's deeper intolerable feelings of emptiness. They suggest, "If the patient then identifies with the container/therapist over time, the self-representations can be reintrojected in a form modified by the empathic, consistent analyst. In summary therefore it is essential both in theory and in practice, to look beyond the dramatic and provocative observable behavior of eating disordered patients. The central issue is not the voracious or infantile, rageful underlying drive state of such individuals. Rather the quality of early ties have prompted anorexics (and bulimics) to self-hate and disgust, denying and disassociating their reasonable need and desire that are merely human" (p. 102). Over time an informed therapist may be able to provide a patient's unmet self-object needs. This could provide the individual with a stronger sense of "self," gradually diminishing her reliance on the problematic behaviors she has instated to mask intolerable desires for unmet needs and gratification.

Prognosis for eating disorder recovery is low; with chances of leading a normal life drastically decreasing the longer the disorder goes untreated. Previous theoretical frameworks have fallen short of explaining the deeper interpersonal struggles that these patients often

possess. Kohut's theory could help treatment teams withhold judgment of the observable behaviors and presentation of severely emaciated clients. This could promote deeper understanding of the factors that have left these individuals more vulnerable to neurosis. Self-psychology offers an alternative way to conceptualize anorexia by suggesting that these patients' manifesting behaviors result from less than adequate infantile self-object relationships. Berzoff et al., (2011) state that "Self-psychology offers a way of understanding not only what was missing, but what can be provided via new relationships (therapeutic and other) to make healing and growth possible" (p. 166).

Through the lens of self-psychology anorexia could be seen as a maladaptive response to early unmet needs for gratification and acceptance. These early childhood experiences may foster intolerable feelings of self-hate and neglect. Anorexia may provide the individual with a false sense of security by allowing them to feel they can ignore these impulses without the use of successful self-object relationships (Mollon, 2002; Wassell-Kuriloff & Rappaport, 1987). Williams and Reid (2012) state, "Anorexia nervosa has been considered to play an ego syntonic and functional role because the resultant feelings of control and thin body agree with the goals of the self. Functional avoidance is beneficial in protecting the person from negative affect, but detrimental because long-term goals are disabled and negative affect is not address" (p. 799).

As outlined by Wassell-Kuriloff & Rappaport (1987), it is the therapist's job to foster the recreation of these early interactions in the transference, gradually instilling feelings of strength and independence. Over time patients may be able to tolerate deeper issues of self-worth and self-expression without relying on the behaviors that have aided them with a false sense of omnipotence. Berzoff et al., (2011) propose that "If you can name troublesome feelings you can begin to master and transform them, because you have a fuller, more accepting knowledge of

yourself” (p. 166). Allowing the anorexic patient to tolerate their desires for gratification and acceptance, may promote the recreation of positive self-object functions. Through the use of mirror and idealization transference the therapist can foster transmuting internalization of her functions, thereby helping the patient to feel more “genuine and authentic” by accepting her previously intolerable impulses (p. 166).



## Chapter V

### FAMILY SYSTEMS THEORY

This chapter will review key components of Murray Bowen's family systems theory. The chapter will outline the concepts of differentiation and enmeshment that are most relevant to understanding and treating families of anorexic patients. The chapter will conclude with an outline of familial intervention strategies in the hope of supplying an additional way to conceptualize and understand the systematic complexities possibly underlying the disorder.

Family systems theory is a clinical tool used to understand the environmental effects on individual functioning by providing a broader focus on the "ongoing dynamic processes in the family network of relationships" (Walsh, 2012, p. 40). Family systems theorists believe that the success of interpersonal and parent-child relationships result from "family-of-origin" experiences (Walsh, 2012). This perspective takes into account object relations, attachment and developmental theories to provide a richer understanding of family patterns and trans-generational influence. Applications of family systems theory can provide clinicians with a deeper explanation for human behavior by exploring the environments to which individuals are exposed. This theory postulates that familial relationship patterns can help or hinder treatment interventions. Psychotherapist Paul Wachtel (2011) states, "A great deal of living goes on outside of the context of the therapeutic relationship, and what transpires between the patient and other important people in his life can make the crucial difference between whether change is maintained or is continually undermined and short-circuited" (p. 116). Family systems theory is an important facet in the conceptualization of treatment for anorexia nervosa, as it often manifests in early adolescence, affecting both the individual and the family unit.

A family system is defined as a group of individuals who share a biological, emotional, and/or historical past. It is a working unit that places equal emphasis on the well-being of the individual as well as that of the group. When at optimal functioning, it is a source of shelter, love and compassion for all individuals involved (Goldenberg & Goldenberg, 2012). Murray Bowen (1978) was a psychiatrist and family theorist who developed an alternative way to view family emotional systems by suggesting that they lay along a continuum. Bowen observed that individual family units could present levels of functioning anywhere from severely impaired to those performing at optimal levels (Walsh, 2012). Bowen believed that a number of processes could lead to a family's structural dysregulation or impaired functioning. He provided a therapeutic outline that suggested more than just symptom reduction, advising therapists to explore family histories in order to resolve engrained intergenerational conflicts (Walsh, 2012).

### **Key Components of Bowen's Theory**

Bowen believed that variability in family functioning was accounted for by the family's level of differentiation and the emotional fusion between members. Differentiation is defined as "the capacity of the individual to function autonomously by making self-directed choices, while remaining emotionally connected to the intensity of a significant relationship system" (Kerr and Bowen, 1988). Emotional fusion is defined as the process which results from poor differentiation. This is demonstrated when "individual choices are set aside in the service of achieving harmony within the system" (Brown, 1999). Individuals in emotionally fused relationships react to the demands of a family member in order to remediate the problem without contemplating the consequence of their actions. Families with more emotional fusion invest large amounts of energy in either taking things personally (to ensure the comfort of another) or in extreme distancing (ensuring one's own comfort) (Brown, 1999).

Bowen felt that most families maintain a normal level of differentiation, allowing the unit to adapt to daily stressors while simultaneously maintaining individuality and emotional space. This allows the unit to support individual members through stressful events without becoming emotionally fused to the anxieties and issues of the struggling member.

Walsh (2012) writes:

Most families were thought to function in the moderate range, with variable cognitive and emotional balance and some reactivity to others in need for closeness and approval. In families with moderate to good differentiation of self, couples are able to enjoy a full range of emotional intimacy without losing their individual autonomy. Parents can encourage their children's differentiation without undue anxiety or attempts to mold them. Family members take responsibility for their own behavior and do not blame others. They can function well alone and together. Their lives are more orderly, they can cope with a broad range of situations, and when stressed in dysfunction, they use a variety of adaptive coping mechanisms to recover rapidly (p. 41).

Bowen believed that individual and family dysfunctional patterns were a product of a number of internal family processes. However, he held that the two key components to family dysfunction were emotional reactivity and poor differentiation (Walsh, 2012). These aspects explain a family's inability to successfully solve issues or to provide the space for independence and personal growth (Walsh, 2012). Bowen held that emotional reactivity and differentiation are continual and inevitable processes that are enacted as an attempt to maintain the stability of the unit. If these processes become maladaptive they have the potential to affect the mental health of the unit's individual members (Brown, 1999).

The process of triangulation or "triangling," is the natural process that occurs when two members (often parents) in a state of anxiety (emotional reactivity) include a vulnerable third party (child) to help distract them from their unresolved conflict. This process is used to temporarily relieve relationship anxiety by distracting from the problem. Bowen held that triangulation was an inevitable coping mechanism used to handle relational and environmental stressors. However, he felt this process could become problematic if used to avoid solving deeper family conflicts (Brown, 1999). Bowen identified that triangulation patterns tended to repeat across generations, with families often using new members to fill the roles of the deceased i.e., caretaker, mediator, comedian, troublemaker and so on.

The family projection process is the process in which parents transfer their own emotional anxieties onto the child (Brown, 1999). This process is also believed to occur across generations and has the greatest effect on the child with the least amount of differentiation from the family unit. This process occurs when the manifesting behaviors or symptoms of a family member are misidentified as the root of the problem instead of the response to the unit's dysregulation. For example, a child acting out in school would gain the attention of their parents, inhibiting the couple from focusing on the relational issues that had sparked the child's behaviors in the first place. In this process the manifestation of symptoms becomes the focus of the unit's energy instead of the transactional patterns that are causing the problems to occur (Brown, 1999).

The final process, relevant to Bowen's adaptation of family systems in relation to anorexia nervosa, is emotional cut-off or extreme distancing. This process explains an individual's complete emotional and or physical disconnect from the family unit. Bowen states, "If one does not see himself as part of the system, his only options are either to get others to

change or to withdraw. If one sees himself as part of the system, he has a new option: to stay in contact with others and change self" (Kerr and Bowen, 1988, pp. 272-273). Bowen felt that emotional cut-off would naturally occur between members if a system was continually dysregulated. Individuals unable to see themselves as a part of the functioning unit would either physically or emotionally withdraw from the system, holding the idea that change was unachievable.

Bowen's model of family system's theory places the therapist in a less active and more observant role. He felt the therapist's job was to help guide the family into a deeper exploration of their own relationship patterns, generational influences, and forms of communicating. Bowen held that remediation of a patient's presenting symptoms only works as a temporary "band-aid," particularly if the therapy fails to address a much larger systems issue. He suggested that by identifying less than optimal family dynamics, individual members could take responsibility for their role within the system and "achieve, richer, deeper relationships not blocked by emotional reactivity, fusion, or distancing" (Walsh, p. 43).

Many studies have examined the type of familial interactions present in families with a member troubled by anorexia nervosa. The following will present key components of Bowen's theory presented in the empirical research, with the hope of identifying the efficacy of family system's knowledge when entering into treatment with individuals experiencing anorexia.

## **Differentiation**

Family differentiation levels have been used as a way to explain individual vulnerability to a number of mental health issues. Data from the examination of extensive studies show that the anorexic female has often demonstrated a fear of transitioning into adulthood and an inability

to successfully separate from her family. Poor differentiation has been a key factor in explaining the prevalence of anorexia in adolescence, a time that should be defined by increased differentiation and less enmeshment. Sue et al. (2010) write, "The girl with the disorder has problems with maturation. She is afraid of having to grow up, which would lead to having to separate from her family and develop her own identity" (p. 456). Anorexia research has suggested that individuals resort to food restriction as a means of preventing maturation and menstruation, fueled by the fear of independence and separation from the family unit (Bruch, 1978; Halmi et al., 2000; Sands, 2003). Understanding developmental fears and poor differentiation patterns may help therapists address underlying issues in the patient's family environment. Through interpretation of dysfunctional patterns, treatment teams may be able to view a patient's relationship with the family as a continual and reciprocal process. This perspective may increase clinicians' ability to identify the way familial patterns have affected the patient. Understanding the anorexic female's possible fear of differentiation, as resulting from parent-child relationships, may allow therapy to address the maladaptive interactions that have fueled symptom manifestation and prevented optimal system functioning.

### **Familial Pressure**

There are a number of research studies suggesting that parent values and family weight issues may increase disordered eating behaviors (Sue et al., 2010). Familial relationships can promote eating disorders by placing unnecessary focus on weight and dieting. Additionally, individual body dissatisfaction can be exacerbated through the use of body shaming comments and the observed eating habits or dieting rituals of other family members (Vincent & McCabe, 2000). Etiological explanation from this perspective suggests that families can work to either "buffer" unrealistic cultural standards of beauty or, knowingly or unknowingly, reinforce

society's distorted body image ideals (Sue et al., 2010). Addressing the way that families engage in the eating process and their attitudes towards weight and dieting may help identify patterns that have unknowingly increased the patient's vulnerability to the disorder.

### **Communication Patterns**

Research has suggested that certain types of family communication styles and interactional patterns may increase an individual's likelihood of being diagnosed with anorexia (Bruch, 1973; Crisp, Harding, & McGuiness, 1974; Humphrey, 1986; Kluck, 2010; Kog & Vandereyken, 1989). The adaptation of a family systems approach to treating anorexia has stemmed from the empirical data suggesting that a child has been influenced by a number of these familial factors. Researcher's Shruger and Kruger (1994) set out to measure the communicative patterns in the families of 15 high school age females with anorexia. The results showed that an individual's level of weight gain throughout treatment was highly correlated to the type of communication styles found in her family. Patients whose families demonstrated more aggressive patterns of communication (covert, indirect, overt) yielded lower overall weight gain than those with more direct communicative patterns. The study suggests that therapy may not be successful if negative communication patterns are not first identified. Shruger and Kruger's (1994) empirical data place emphasis on the importance of not only identifying these patterns but also helping the family shape them into more effective forms of communication. This could ultimately promote the resiliency of both the unit and the individual in the face of future stressors, including those related to disordered eating.

## **Family Based Therapy vs. Individual Based**

As new treatment options for anorexia are identified, researchers have begun to analyze the efficacy of current treatments. A longitudinal quantitative study conducted by Lock & Le Grange (2001) compared 121 adolescents with anorexia, treated by two separate types of therapy. In the study, 61 of 121 females were given family based therapy over the course of 12 months while the remaining 60 received focused individual therapy. The study revealed higher numbers for full remission in individuals who received FBT at both the 6 month and 12 month mark (Lock & Le Grange, 2001). This study suggests that family involvement can increase treatment efficacy.

### **Type of Family Based Treatments (Conjoint/Separated)**

Issues surrounding the involvement of the family system and the level to which it is effective were addressed through a randomized control trial (Eisler et al., 2007). This study compared conjoint family treatment and separated family treatment types and their effect on long-term treatment goals. Conjoint family treatments (CFT) are defined as therapeutic sessions in which the entire family is seen. Separated family treatment (SFT) involves separate sessions for the parents and the individual utilizing the same therapist. Forty individuals were assessed after receiving 6 months of treatment. After five years 38 of the 40 individuals were interviewed about remission or symptomology present throughout the time lapse. Results showed slightly higher restoration of body weight in the individuals who received SFT but these differences were slight and deemed insignificant. Seventy-two percent of individuals who received CFT and eighty percent of those in the SFT saw positive outcomes (Eisler et al., 2007). It is important to note that the individuals treated in this study had a long prevalence of the disorder and had



previously received failed treatments. Outcomes show that distinguishing between family group therapy opposed to individual family therapy sessions may not predict the success of treatment.

### **Factors that Effect Treatment Efficacy**

#### **Presence of Fear and Blame**

Some research has suggested that resistance to treatment can arise from conflictive factors in both the patient and family. One longitudinal study looked at the lack of research applied to the fear based components that often reside in an eating disorder diagnosis (Hidderbrandt et al., 2012). The fears that were assessed included: parental fear of external judgment, sibling fear of contracting the disorder, individual fear of the disorder being discovered, and the internalized parental fear of being blamed. This study explored whether these fears prevent family based treatments from becoming successful. The study's sample size was limited to one family whose individual member had struggled with the disorder for the duration of 6 months. The study found that individual triggers were too difficult to decipher for the person experiencing eating disordered behaviors and that the disorder itself was often very personal for the family unit (Hiddebrandt et al., 2012). This case study may help to explain the importance of identifying the multifaceted aspects that can contribute to anorexia nervosa. By identifying individual and family anxieties centered on the disorder, therapists and social work clinicians may be able to counteract avoidant patterns that could inhibit treatment success.

#### **Implications for Practice**

The overarching goal of therapy, based on Bowen's theory, is to decrease the anxiety levels within the family unit. Remediation of structural anxiety will promote higher functioning and resiliency in both the individual and the system. Therapeutic intervention is achieved by

guiding individual members to a deeper awareness of family relational patterns. Changes to the system are made through the self-reflection and increased accountability of individual members. Bowen's theory emphasizes the importance of making changes to individual behavioral patterns instead of focusing on making changes to others (Brown, 1999). This ultimately results in higher levels of differentiation and changes to the system as a whole.

Family systems theory is particularly relevant to the treatment of anorexia nervosa because of the common manifestation of symptoms in early adolescence. This is a time when the child is expected to transition into adulthood by increasing differentiation from the family unit and decreasing emotional fusion to particular members. Bowen's theory suggests that family transactional patterns may have inhibited the anorexic patient from successfully separating from the family, causing unresolved levels of anxiety that manifest in disordered eating symptoms.

Family systems theory suggests that individualized therapy may place heightened attention and energy on the child's manifesting symptoms, possibly disregarding relational issues and parental influences that may have fostered the disorder. Furnham and Hume-Wright (1992) state "Family systems theory supports the premise that family organizations and behaviors are related to the development and maintenance of anorexia nervosa. One aspect of this is the inability of the parents to adjust to their child's maturing over adolescence and changing from a child into an adult" (p. 22).

Therapeutic intervention through the lens of Bowen's theory could help to address deeply imbedded patterns of dysregulation within the family system. Bowen held that triangulation patterns and emotional fusion would be heightened in the face of severe trauma or stress. Manifestation of the anorexic patient's symptoms could be seen as a sign that the unit is not

adequately supporting its individual members and that changes need to be made to promote future resiliency.

The following chapter will summarize the key points presented in chapters four and five in order to emphasize the main points used to synthesize the two theories. A hypothetical case example will be presented in order to apply family systems theory and self-psychology perspectives when conceptualizing and implementing future treatment interventions.

## **CHAPTER VI**

### **CONCLUSION**

The aim of this theoretical thesis was to examine the ways that self-psychology and family system's theory may contribute to a more inclusive understanding of anorexia nervosa. Chapter three introduced the phenomenon of anorexia, a life threatening and complex psychological disorder that is growing in diagnostic prevalence (Sue et al., 2010). It reviewed the etiological factors that have been used to conceptualize a predisposition to the disorder, and it included findings from a number of empirical studies examining the commonalities in patients' neurobiological, family transactional patterns, environmental pressures, and child rearing experiences. This literature suggested that individuals at greatest risk are females between the ages of 15-22, who demonstrate heightened levels of perfectionism and a need for control (Brumberg, 1988). It also suggested that certain family dynamics and individual personality traits enhance one's vulnerability to the socio-cultural and developmental influences of early adolescence (Bruch, 1973). The anorexic female has been described as a selfless individual who often denies her own need for sustenance in favor of meeting the needs of others (Goodsitt, 1997).

Chapter four presented Kohut's theory of self-psychology as a possible lens for understanding the psychological struggles of the anorexic patient. Kohut's theory outlines the importance of meeting the primary self-object needs for twinship, mirroring, and idealization. If a child has less than adequate self-object relationships and the idealized qualities of primary caregivers are not internalized, she will lack the ability to form a cohesive self. Failure to

establish self-cohesion can result in the continual and maladaptive use of self-objects as a means to maintain self-preservation and restore vitality. Without the adequate provision of early self-object needs an individual may lack healthy self-esteem, ruminate on individual failures and demonstrate a deficiency in setting realistic personal goals (Kohut & Wolf, 1978). Kohut observed that these individuals did not respond well to traditional psycho-analysis. This led him to suggest a form of therapy that offered patients a restorative empathic relationship that could engage with the patient in a way that would meet the needs for twinship, mirroring and idealization.

Chapter five outlined Murray Bowen's theory of family systems to explain the impact that environmental and interpersonal relationships may have on the anorexic individual. This theory outlines the way that family functioning, such as enmeshment and lack of differentiation, can unknowingly enhance individual member's likelihood of developing a psychological disorder. Bowen's family system theory focuses on fostering optimal family functioning by uncovering individual members' responsibility for unit dysregulation. This ultimately promotes deeper levels of empathy and encourages differentiation. Treatment utilizing this theoretical framework focuses on identifying the family transactional patterns, individual roles, and generational influences that have led to unit dysregulation. Bowen formulated that remediation of a patient's symptoms could not be fully addressed without first looking at the familial environment to which they are most frequently exposed.

This concluding chapter will present a hypothetical case study to provide exemplar application of self-psychology and family systems approaches to the treatment of anorexia. The case illustration will be formulated by the writer based on the common features of real case examples found in the literature reviewed in previous chapters. Following the application of

both theoretical perspectives individually, a synthesized theoretical outline will be presented to address the familial and developmental aspects perpetuating disordered eating symptoms. It will conclude with suggested implications of using this synthesized theory for practice with individuals troubled by this complicated disorder. It will also address the study's limitations and its implications for future research.

### **Case Illustration: Meg**

Meg was a seventeen year old Caucasian female who had been referred to an outpatient treatment team specializing in eating disorders at the request of her parents. During intake it was explained that within the last seven months Meg had begun to drastically lose weight (20 pounds), withdraw from her family, and refuse to attend family meals. In recent months Meg's mother explained that Meg would weigh herself multiple times a day, and had begun to seriously restrict her caloric intake.

### **Family Composition**

Meg grew up in an upper-middle class family with an older brother (23) and her two birth parents. The family lived in the suburbs of Massachusetts and was active within their community. Meg's father was a high profile lawyer in Boston and Meg's mother was a more recent stay at home mom. Meg was medically underweight when she began treatment and was difficult to engage in conversation. She entered the office behind her parents and avoided questions about her eating patterns. As reported by her mother, Meg was reluctant to attend treatment, insisting that she was "perfectly fine" and did not need the level of care her parents wanted her to receive. Meg's mother was visibly anxious upon arrival, reporting that she was incredibly worried about the safety and well-being of her daughter.

### **History**

Meg's parents reported that Meg was a relatively quiet child who slept through the night and rarely demanded her parents' attention. Meg's mother recalled that Meg had taken a stronger liking to her father at a young age. However, Meg's mother reported being the main parental figure throughout her children's upbringing, emphasizing her ability to raise both Meg and her brother while maintaining a part time job. Meg's mother reported that this had been a very difficult time for her, a time that she felt somewhat abandoned by her husband and burdened by her children's emotional demands. She stated, "With my husband gone so often on work trips, I don't know what I would have done without Meg around the house. She was very independent from a young age, making things a lot easier on me."

When Meg was two, her brother Tim (then 7) was diagnosed with a learning disability. Meg's mother recalled that Tim's cognitive and emotional demands often consumed most of her time and attention. She confessed, "At times I had to rush through the feeding process with Meg because Tim would be acting out for my attention. I regret this greatly, but Meg always had a much milder temperament and allowed me more flexibility." Meg's mother referred to her as a "blessing" stating that she alleviated familial stress by being "such a well-behaved child." Her mother stated, "Meg was quiet compared to her brother. Once she was old enough she often took care of herself, allowing me the time to address Tim's issues." The family reported that Tim was later able to find an outlet through sports, becoming the star of his high school basketball team. Tim had gone on to receive a sports scholarship to a prestigious college and had moved out of state to attend.

When Meg started treatment for her eating disorder she was entering into her senior year of high school. Meg's father was still working as a lawyer in Boston. Meg's mother had retired alluding to her husband's absence as the contributing factor for leaving her job. Meg's father

remained unresponsive to her comments, quietly turning his head and rolling his eyes. During further questioning Meg's parents described her as an academically driven child explaining that she received excellent grades throughout her high school career. Meg's mother stated that Meg had never had issues with school or behavioral problems, and that they had never worried about her like they had her brother. Meg's mother described her relationship with Meg as "very close", explaining that Meg had kept her company while her husband was away. She reported "With my son now gone I would be especially lonely without Meg around. I want my baby to get better so things can go back to the way they were."

### **Observations in Family Session**

During the initial session with the family, Meg's mother did most of the talking. She often answered questions for Meg, explaining to the therapist what she observed to be going on in Meg's world. Meg's father appeared emotionally distant, often checking the time on his watch and appearing physically uncomfortable throughout the session. Meg's parents sat on opposite sides of the couch, with Meg in the middle, rarely engaging in conversation with one another. When the therapist posed a question to the parents regarding their relationship, Meg's mother grew defensive asking the therapist what relevancy that had to her daughter's condition. Meg's father apologized for his wife's quick response explaining to the therapist, "It has been a stressful time for my family, and we are all just very worried about Meg."

### **Observations in Individual Session**

Meg spoke mostly about her mother in the individual session, reporting "My mom will miss me when I leave for college. I know she would like me to stay closer to home." When asked her opinion on the matter, Meg stated that she was still unsure where she wanted to go to school. She confided that she wished she was as "decisive and independent" as her brother. Meg



avoided questions about herself responding that “there wasn’t much to say.” When asked about her childhood Meg stated that it was a “good up-bringing,” saying that her mother was often busy with her brother’s behavioral and emotional demands. Meg recalled a distant relationship with her father, something she attributed to his frequent travel due to work demands. Meg recalled nights where she put herself to bed due to her father’s absence and her mother’s focus on disciplining and assisting her brother with homework. When questioned how this made her feel, Meg quickly responded “I do not resent my mother, I admire her for all she has accomplished. I was perfectly fine taking care of myself and now we are very close.” When topics came up about Meg’s current weight and her severely emaciated appearance she immediately diverted the conversation to the therapist, asking questions about her personal life.

### **Self-Psychology Perspective**

Chapter four introduced Kohut’s theory of self-psychology and the importance of meeting early self-object needs. Individual’s that do not receive adequate mirroring, twinship, and idealizing self-object experiences may lack the ability to develop a cohesive self. Meg’s story represents aspects of early self-object failures that may have increased her risk for anorexia nervosa. Meg was born a second child, six years behind her older brother. During a pivotal time in Meg’s early development, her mother was busy attending to the emotional and behavioral demands of her brother, and her father was not emotionally (or even physically) present. Meg’s mother stated that Meg rarely cried throughout childhood and that she was a very well behaved child. Kohut would suggest that Meg’s lack of overt behavioral demands may have enabled her mother to overlook her self-object needs, prioritizing her time and energy towards Meg’s brother. Inability to demonstrate adequate empathy and attention to Meg’s developmental requirements may have inhibited Meg from internalizing feelings of wholeness and security.

Geist writes (2012),

The feeling of being understood allows the child a healthy sense of having created an omnipotent self-object, which, in turn, confirms the perfection of the self. As this sense of omnipotence is sustained by an understanding milieu, empathy fosters not only the slow disillusionments of omnipotence (via transmuting internalization of psychic structure), but also the continuation of omnipotence in the form of the capacity to create; to play symbolically with fanciful ideas and feelings over which one has absolute control. Thus empathy becomes the guardian of creative potentiality (p. 2).

Meg's mother reported early feeding interactions that were brief and often interrupted. Kohut would suggest that the abrupt and stressful nature of these imperative moments may have prevented Meg from developing important attachment opportunities that are fostered between mother and child through physical closeness and the gratification of nutritional demands. Inability to internalize confidence in her mother's empathic responsiveness to early sensory and nutritional needs may have prevented Meg from establishing the confidence to express later emotional and physical desires.

Kohut's theory of self-psychology suggests that Meg lacked adequate attachment to her mother and father, both failing to provide her with the self-object relationships needed to form a cohesive self. As a child, Meg reportedly grew attached to her father. However, he was often out of town, most likely unable to provide the adequate time and attention needed for mirroring, twinship, and idealization processes. Kohut would suggest that as Meg grew older, she accepted her parents' inability to meet her innate self-object needs, resulting in low self-worth and a fragmented sense of self. Meg's parents may have overlooked opportunities to praise her for her accomplishments, mirror her individual skills, and model realistic personal goals and aspirations.

In addition, their overemphasis on Meg's independence may have inhibited the important early relationships she needed to form a cohesive self. This deficit may have prevented Meg from formulating a healthy self-esteem that would allow her to feel confident expressing early developmental demands.

Self-psychology theorists postulate that the anorexic female is often "willing to put themselves at the service of others" placing individual needs behind those of her family (Curiel-Levy et al., 2012). Meg's resistance to treatment could be defined by her deeper feelings of insignificance and selflessness. Goodsitt (1997) writes, "She (the anorexic female) cannot imagine that other people would be willing to give up, even temporarily, their interests and viewpoint in order to fulfill her needs"(p. 1). Self-psychology suggests that deeply laden feelings of low self-worth formulated by less than adequate early childhood experiences may have left Meg more vulnerable to external failures. The absence of optimal mirroring and idealization may have convinced Meg she was unworthy of praise or attention. These deficits in early developmental relations could lead to intolerable feelings of guilt when receiving the attention and empathy of others.

Kohut's theory supplies a possible explanation for Meg's presenting symptoms by suggesting that the less than adequate provision of self-object needs has left her more vulnerable to developing anorexia. Meg's inability to form a cohesive self in early childhood may have left her with a deepened fear of self-expression and an inability to self-regulate. Failure to internalize the idealized qualities of her primary caregivers has resulted in Meg's heightened awareness of other's needs, while simultaneously lacking the ability to identify and verbalize her own (Curiel-Levy et al., 2012). In the face of her current adolescent developmental milestone, defined by moving out and becoming an adult, Meg's fractured sense of self may have employed

defenses to protect her from internal fragmentation. By utilizing maladaptive coping mechanisms (restrictive eating patterns) Meg's psyche may paradoxically have provided her with feelings of independence, omnipotence, and individuality. Researchers Williams and Reid (2010) write, "Anorexic thoughts and behaviors become a way of being independent and in control, but in a very limited and dysfunctional domain. Anorexia nervosa typically develops during adolescence, a time of significant social and biological change during which the person may have concerns about his/her sense of self and feel the need to exert some control in his/her life" (p. 798). Kohut believed that individual's with less than optimal self-object experiences would resort to false displays of power in order to avoid unmanageable feelings of low self-worth. Meg's manifestation of symptoms may explain her psyche's attempt to protect her from internal fragmentation. Restrictive eating behaviors may have provided her with temporary feelings of control, buffering the more unmanageable emotions she is unable to identify or express.

### **Family Systems Perspective**

Family system's theory offers a complementary way of understanding anorexia nervosa through the analysis of family transactional patterns. Bowen held that remediation of a patient's symptoms could and would not be achieved until the family system was brought to a more optimal level of functioning, proposing that psychological disorders were the direct result of family dysfunctional patterns (Brown, 1999). A number of studies reviewing similarities in the families of anorexic females have shown patterns of enmeshment, conflict avoidance and the overprotection or coddling of individual members (Shrugar & Kruger, 1994).

During the family session Meg's mother appears bitter regarding the need to leave her job, applying underlying blame to her husband. She emphasizes the role Meg has played in keeping her company. Bowen's theory suggests that Meg's mother is compensating for a void in

her marital relationship by relying on her daughter to compensate for her husband's absence. This process may be prohibiting Meg from successfully differentiating and leaving the house, placing her in the middle of her parent's marital issues. Meg's inability to decide on a college, and her emphasis on her mother's needs instead of her own, may be understood through enmeshment patterns. Bowen held that enmeshed family members will take on the responsibilities and needs of other members in order to achieve conflict resolution and eliminate system anxiety (Brown, 1999). This process is often enacted by meeting the needs of others, while placing one's own needs in the background. Meg's inability to formulate a decision about where to go to college may be reinforced by her mother's reliance on her presence at home. Family studies have found commonalities in the mother/daughter relationships of patients with anorexia. Analysis of these findings has suggested that the "typical" mother places heightened emphasis on their daughter's ability to supply her with companionship and comradery (Blinder, Chaitin & Goldstein, 1988). This pattern of enmeshment and dependency may lead to the child's later inability to successfully complete maturation and separation from the family system.

Data on common behavioral patterns in the parental dynamics of anorexic females have shown mothers to be more controlling, while fathers remain more withdrawn and emotionally distant (Furham & Hume-Wright, 1992). Avoidant communication patterns may decrease a family's ability to address pressing familial issues. Psychologist Whitney Spanuth (2014) writes, "Members of these families seldom take specific stands on issues, and conflict is avoided at all costs. Underlying dissatisfaction and tension is often present within the parental dyad. It has been suggested that parents of anorexic offspring put high expectations on their children to over-compensate for the lack of love in their own marriage" (p. 1). This phenomenon can be seen in the family session with Meg and her parents. In the session Meg's parents sat on opposite sides

of the couch with Meg placed in the middle. Bowen believed that the most enmeshed child had an increased vulnerability to the triangulation patterns enacted by other family members (often parents) to avoid addressing uncomfortable relational issues. Meg's mother's overt personality in combination with her father's withdrawn demeanor could be placing pressure on Meg to remediate the stress between the two parties. Meg's mother demonstrates a need for control in her tendency to speak for Meg throughout the session, and this is indicated in her response to the therapist during enquiry about the marital relationship. Meg's father demonstrates emotional distancing through his disengagement during the session, and his passive aggressive response to his wife's behaviors. Bowen may postulate that Meg's parents have unknowingly triangulated Meg into their relationship in order to avoid deeper marital and relational problems. By focusing the family's energy on Meg's presenting symptoms the family may be neglecting to address the processes that have perhaps fostered the disorder in the first place.

Research suggests that the anorexic female has an underlying fear of differentiation resulting from parental demands and the inability to promote their child's maturation and transition into adulthood. Psychologists Furnham and Hume-Wright (1992) state, "Family systems theory supports the premise that family organizations and behavior are related to the development and maintenance of anorexia nervosa. One aspect of this is the inability of the parents to adjust to their child's maturing over adolescence and changing from a child to an adult" (p. 21). Meg's inability to decide where she wants to attend college and the manifestation of symptoms leading up to her decision could be further explained by the underlying pressures placed on her by her parents. Application of family systems theory stipulates that restrictive eating patterns allow the individual to prolong childhood by preventing maturation and menstruation. Furnham and Hume-Wright (1992) state, "Fear of moving into adulthood may

intensify to the extent that the potential anorexics do not wish to grow up; this refusal results in a refusal of the perceived agent of growth: food. By refusing to eat, and the consequent illness, children can prolong their childhood, practically forcing their mothers to continue to care for them as though they are still children" (p 23). Meg may unknowingly be enacting restrictive eating patterns in order to prolong her ability to remain with her family. Unsuccessful fostering of Meg's developmental needs have placed Meg at the service of her parents' needs: a container for the family's deeper dysfunctional patterns.

### **Synthesis of Self Psychology and Family Systems Theory**

It is now possible to provide a more comprehensive model to understand and treat anorexia nervosa. The previous chapters have outlined self-psychology (chapter 4) and family systems (chapter 5) theoretical perspectives used to view the etiological factors of the disorder. While the application of either theory alone might neglect to identify an imperative portion of the disorder, by combining self-psychology and family systems perspectives practitioners may be better able to navigate and address the individual and family based components vital for long-term recovery.

Therapy with the individual anorexic through the lens of self-psychology could work to repair the damaged psychic structure of the individual, offering reparative functions through the provision of positive self-object relations. However, the implementation of self-psychology theory unaccompanied by a family systems approach would return the vulnerable patient to the unchanged environment, likely influential in precipitating and perpetuating the disorder. Conversely, implementation of a family systems approach without the inclusion of self-psychology could leave the patient solely reliant on the resiliency of the family and the support of its members. This may heighten the patient's dependency on the unit's ability to supply

individual needs, further preventing successful differentiation and maturation. By combining individual therapy informed by self-psychology together with family systems interventions, therapists may be able to decrease relapse rates by supporting the individual at both the intrapsychic and the interpersonal familial levels.

### **Treatment Outline for Individual Based Therapy**

Treatment through the lens of self-psychology focuses intervention methods on the self-object disruptions or narcissistic insults that have occurred in the patient's life (Baker and Baker, 1987). This framework looks at symptom manifestation as a result of early self-object failures or narcissistic injuries. Self-psychology would understand anorexic symptoms as the patient's attempt to restore "vitality" in the face of psychic threat. The therapist's job is to encourage discussion of these behaviors without openly approving or disapproving of their significance to the patient. Baker & Baker (1987) write, "Accepting the most trivial of a patient's demands as important may seem prima facie, an unreasonable acceptance of the most irrational of the needs. What is meant, however, is empathically acknowledging how important the need (to restrict food/maintain a low weight) is to a patient" (p. 7). Kohut discourages therapists from prematurely correcting the patient's distorted coping mechanisms or manifesting symptoms, suggesting that these corrections can risk destroying the reparative self-object transference imperative for treatment success.

Kohut believes that the reparative process needed for patients with fragmented self-object ties requires both time (frequently long term treatment) and stamina of both patient and therapist. Success of treatment is dependent on the therapist's ability to provide the patient with reparative self-object functions through empathic understanding. This process requires the therapist to accept the patient's distorted thinking and self-destructive behaviors as true and meaningful to



the patient. The process of providing the patient with empathic understanding “resumes the (patient’s) thwarted developmental process, forming internal structures that assume the functions provided by the self-object” (Baker & Baker, 1987). Once adequate self-object ties are formed between patient and therapist, the patient is able to internalize the restorative self-object functions of the therapist. This process provides the patient with the ability to transform previous self-object relationships from archaic to mature, ultimately leading to self-cohesion.

Self-psychology can help the therapist appreciate the frequently fragile nature of anorexic patients when first entering therapy. The theory emphasizes the importance of the therapist's ability to accept the patient's behaviors and beliefs (food restriction/fear of being fat) as critically meaningful without approving of them (Baker & Baker, 1984). Baker and Baker (1984) write, "only after the self has been sufficiently consolidated through the sustenance of the self-object failures can patients begin to see how the urgent intensity or vulnerability they experience is a reaction based on early self-object failure" (p. 7). In other words, remediation of eating disorder symptoms may not be successful until the patient has been provided with a restorative self-object tie that allows her to internalize a more cohesive structure able to examine the meaning of her disordered eating. This process is completed by the successful internalization of the mirroring, twinship and idealized qualities of the empathic therapist. Self-psychology suggests that only when self-cohesion is restored, can the patient begin to approach the deeper emotional issues of self-hate, disgust and guilt that are postulated to underlie the disorder. As self-cohesion increases, the patient may be able to be more curious and insightful about her own behaviors and about her relationships with family and others.

### **Treatment Outline for Family Based Therapy**

Treatment intervention through the lens of Bowen's family system theory addresses negative family transactional patterns through three core steps. The first step works to reduce both the patient's and the family's anxiety around the disorder. This can be particularly effective in the treatment of anorexia nervosa, as there are often overwhelming feelings of guilt presented by both the patient and the parents. Therapy sessions begin with the patient and parents in order for the therapist to explore familial history and identify communication patterns. The therapist is then encouraged to meet with the parents separate from the patient, allowing for the de-triangulation of the child from the parental unit. Bowen held that this process would allow the therapist to guide the couple in exploring the reactivity, anxiety and communication patterns that may have negatively influenced their child. It is important, in this phase of treatment, for the therapist to encourage individual self-exploration while avoiding blaming patterns between the dyadic pair. The therapist is encouraged to enquire about individual feelings, directing questions to individual members rather than promoting dialogue between both parties. Bowen held that this process would increase the family's likelihood of listening and "hearing" the responses of its members without being pulled into patterns of reactivity or emotional enmeshment (Brown, 1999). The final stage of treatment intervention is to coach the entire family into higher levels of differentiation with the hope of decreasing anxiety, enmeshment and emotional reactivity. This phase of treatment, particularly when supporting adolescents with anorexia nervosa, is most effective because parents are often anxious about their child's well-being and safety. Parental fear could unknowingly project individual anxieties onto the child, fueling the disorder. During this phase the therapist encourages parents to "own" and vocalize their anxieties, taking responsibility for them without using blaming statements (Brown, 1999).

Perhaps the most salient intervention in Bowen's system theory is the de-triangulation of members from familial triads. This process assists individual clients in recognizing the ways they have been triangulated by other family members, along with taking responsibility for the ways they continue to triangulate others. During this process the therapist is encouraged to use open ended tracking questions that stimulate deeper exploration of the processes individual members enact to divert from anxiety. Once triangles are successfully identified family members who have been drawn into the triangle are encouraged to take a neutral role in the triadic relationship. This allows the dyadic couple (often the parents) to communicate and successfully resolve issues. By generating less reactive stances in the face of another family member's anxiety the therapist can promote further differentiation and less enmeshment in the family unit.

The therapist's role throughout this experience is one that guides the family to a deeper understanding of the unit as an "emotional system." (Brown, 1999). This process involves the therapist's attention to the family's patterns of triangulation, being aware that they can become involved in a family triangle at any time in the therapeutic process. It is important for the therapist to maintain a "differentiated stance," asking individual members to speak openly while refraining from passing judgment or interjecting advice. The key role of the therapist, in Bowen's family systems theory, is not to supply the family with a "cure," but to guide them into the position where they are able to accept responsibility for their own change (Bowen, 1971). Brief psycho-education on the patterns of triangulation and differentiation is an important part of successfully guiding the family to a more informed and conscious way of interacting.

### **Follow Up On Meg**

A treatment approach for Meg and her family would begin by addressing the lack of differentiation between her and her mother. The family therapist would address these issues by beginning a discussion about Meg's desire to go to college and the processes of enmeshment and anxiety that may occur at this developmental stage. The therapist would address triangulation issues between Meg and her parents by engaging them in a conversation about their relationship issues, and the ways they may unknowingly place Meg in the middle of their problems. Individual sessions would unravel Meg's deep intolerable fears of individuation and separation by supplying her with adequate self-object relations needed for self-cohesion and self-expression.

The therapist's empathy (mirroring) towards Meg's use of food restriction, as a maladaptive coping mechanism, could allow for the reparation of her less than adequate self-soothing functions. Over time the therapist would work to replace Meg's insufficient self-object relationships by supplying her need for working together "shoulder to shoulder" (twinship) and admiration of accomplishments (idealizing). Once trust and empathy were established between the therapeutic dyad, sessions would work toward addressing Meg's underlying fear of differentiation and maturation. Through the process of empathic mirroring and family systems interventions, therapy would bring all members to a deeper understanding of the ways transactional patterns have unknowingly affected Meg's declining health. This would promote Meg's confidence in her own maturation and individuation processes. In time Meg may be able to establish a cohesive structure that allows for further differentiation from the family. In addition, family therapy would help uncover individual vulnerabilities, equipping the family with the ability to manage and adapt to future interpersonal and external stressors. This would in turn promote individual member resiliency and decrease Meg's likelihood of relapse.

## **In Conclusion**

Approaching treatment for anorexia nervosa through the synthesized lens of self-psychology and family systems theories may help address the multifaceted and deeply engrained aspects of this complex disorder. High relapse rates and the high incidence of unsuccessful interventions have suggested that previous conceptualizations have failed to address all the components necessary for treatment success. The implementation of one theoretical approach without the inclusion of the other would be missing key factors at either the intra-physic or systematic level. Through individual therapy the therapist can work to expose the underlying features of the disorder that have caused the patient to resort to maladaptive attempts for self-preservation. This process would require time and stamina of both patient and therapist, and could require long-term treatment to promote symptom remediation and individual resiliency in response to future stressors. Additionally, application of a family systems approach could incorporate the interpersonal world to which the individual is most often exposed, helping family members address factors that may have placed the patient at higher risk. This process would encourage the participation and support of the family unit, engaging the parental unit in helping remediate previously unsuccessful ways of coping with anxiety. Previous treatment interventions based solely on an individual framework may have overlooked the daily environmental and interpersonal relationships that have likely influenced symptom onset. The goal of this theoretical thesis was to present a more complete formulation of etiological influences in the hope of better understanding and conceptualizing intervention strategies. It proposes that future social work interventions include both a self-psychology and family systems approach in order to provide comprehensive treatment, thereby promoting the long term resiliency of both the individuals and families troubled by this life threatening disorder.

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