UNDERSTANDING ANOREXIA NERVOSA FROM A MULTI-CONTEXUAL PERSPECTIVE

A graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Science in Counseling,
Marriage and Family Therapy

By

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ABSTRACT

A MULTI-CONTEXTUAL PERSPECTIVE OF ANOREXIA NERVOSA

By

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Masters of Science in Counseling,

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This project is designed to inform counselors in the field of Marriage and Family Therapy about the onset and maintenance of Anorexia Nervosa. Graduate students, interns, trainees, and professors in the field may use this project to gather information about this disorder’s root causes. The National Association of Anorexia Nervosa and Associated Disorders (2014) indicate that 30 million people, regardless of their age and gender, suffer from some sort of eating disorder in the United States. There are various theoretical perspectives that explain why people develop eating disorders. This workshop will be used to address the familial, social, and interpersonal influences that could contribute to the onset of this illness. This project will contribute to the field of Marriage and Family Therapy by providing counselors with a workshop that could potentially increase their knowledge about treating clients with this condition. Ideally, this workshop will result in less individuals suffering from Anorexia Nervosa and allow others to understand the complexity of this disorder.
Chapter 1

Introduction

The National Association of Anorexia Nervosa and Associated Disorders (2014) indicates that 30 million people, regardless of their age and gender, suffer from some sort of eating disorder in the United States. Marriage and family therapists or other mental health professionals are some one of the main resources to help individuals suffering from such disorders.

According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed., DSM 5; American Psychiatric Association [APA], 2013), Anorexia Nervosa is characterized by an individual’s intense fear of gaining weight. Unfortunately, people with this disorder usually starve themselves to death out of fear that they will become overweight. The effects of this illness could be devastating and puts many individual’s lives at risk (APA, 2013).

Statement of Need/Problem

The National Association of Anorexia Nervosa and Associated Disorders (2014) reported that 5 – 10% of anorexics die within 10 years after contracting the disease, 18-20% of anorexics will be dead after 20 years, and only 30 – 40% ever fully recover. Thus the number of individuals suffering from this disorder is increasing (2014).

Anorexia Nervosa usually develops in adolescents or young adults (APA, 2013). Unfortunately, it can put a tremendous amount of strain on a person’s family. Loved ones are left feeling stuck and terrified of saying the wrong thing. Parents and other family members are usually highly motivated to help, but don’t know how. Family members or friends often times rely on mental health professionals to treat such conditions.
However, Johnson (1991) contends that psychotherapy has been proven to be an effective form of treatment. It focuses on addressing underlying emotional or mental health issues that trigger the disorder. Often times early childhood traumas or dysfunctions within a person’s family can cause the onset or maintenance of an eating disorder (1991).

Treating Anorexia, along with many other disorders, can be challenging for therapists. Not every individual will have a positive response to the same treatment method. Therefore it is important for therapists to consider different models of therapy when working with clients that have been diagnosed with an eating disorder.

**Purpose of Project**

The purpose of this project is to create a Power-Point presentation that will be available via Internet, on the California State University Northridge (CSUN) website. Students and other faculty members who attend CSUN will have access to the website and will be able to use it for educational research. It is intended to help therapists understand the complexity of this illness. Anorexia can be viewed as a multi-contextual disorder that oftentimes isn’t caused by one particular factor. In fact, therapists should consider the familial, social, interpersonal, and interpsychic aspects that contribute to this disorder. Usually the onset of Anorexia isn’t directed at a single cause, but a combination that is intertwined with one another. Since every individual is unique, the goal of this workshop is to help therapists develop a treatment plan that best suits their client’s needs by considering different factors that could contribute to the onset of this illness.
Significance

Anorexia Nervosa can be a painful and lonely experience for individuals who are suffering from this condition. Marriage and family therapists are often times the only source of hope and optimism for clients who come in for treatment. Education about this illness cannot only help someone find happiness, but it could also save someone’s life.

Individuals are more likely to be successful in treatment if therapists learn to look beyond the specifics of the problem and into its root causes. Using a specific model of therapy can provide counselors with a roadmap or direction as to how to treat individuals with such disorders.

Terminology

The following is an alphabetical list of terminology used:

**Empathy** – In *The Psychiatric Dictionary*, Campbell (1981) defines it as “Putting oneself into the psychological frame of reference of another, so that the other person’s thinking, feeling, and acting are understood and, to some extent, predictable” (p. 215).

**Interpersonal**- Goldenberg and Goldenberg (2013) define interpersonal as “interactional, as between persons” (p. 519).

**Object Relations Theory**- Goldenberg and Goldenberg (2013) defines this term as “The theory that the basic human motive is the search for satisfying object (human) relationships, and that parent-child patterns, especially if frustrating or unfulfilling, are internalized as introjects and unconsciously imposed on current relationships” (p. 520).

**System** – According to Goldenberg and Goldenberg (2013) a system is “a set of interacting units or component parts that together make up a whole arrangement or organization” (p. 523).
In order to better understand this issue, it is important to review previous literature and research regarding Anorexia Nervosa. The next chapter will focus defining anorexia and some of its characteristics. It will also describe the theoretical perspectives that are believed to cause the onset and maintenance of the disorder.
Chapter 2
Review of the Literature

Introduction

This chapter will begin with a discussion of Anorexia Nervosa, including a description of the disorder, symptoms, characteristics, and its prevalence. Next will follow a discussion about different theories that explain the causes of Anorexia Nervosa. The first theory covers the work of Salvador Minuchin. He believed that Anorexia is a psychosomatic disorder that lies within a person’s family system. The next theory is based upon a socio-cultural perspective. This theory posits that a person’s surrounding environment influences his/her behavior. The third theory to be discussed in this literature review is based upon parent-child attachment. The theorists presented believe that eating disorders are caused by an insecure attachment between the child and parent. Finally, the last theory that will be covered is object relations. This theory is based upon the idea that an individual’s interpersonal relationships with others have a significant effect on the ability to form a positive self-image. By reviewing the literature, it is possible to understand that Anorexia Nervosa is a multi-contextual disorder that is caused from various components.

Defining Anorexia Nervosa

According to the DSM 5 (APA, 2013), an individual who suffers from Anorexia Nervosa has an intense pathological fear of becoming fat. Therefore, he/she will restrict food intake or misuse substances such as laxatives, diuretics, or even enemas in order to lose weight (2013). Bryant-Waugh & Lask (2000) indicates that another way individuals with Anorexia will try to lose weight is through excessive exercise. These activities are
usually performed at night or in secret in order to avoid judgment or criticism from others. Individuals with Anorexia Nervosa are known to be tremendously dissatisfied with their bodily appearance (2000). In fact, a person may claim to “feel fat” even when he or she is significantly under his/her normal body weight (APA, 2013).

Treasure (1997) noted that individuals who suffer from Anorexia Nervosa regard food as fattening and unhealthy. In fact, they may find food repulsive. It is common for anorexics to feel a sense of guilt or shame when they do eat. Losing weight becomes a way of life. People with this condition undergo extreme measures in order to lose weight. For most everyday people, it is nearly impossible to tolerate the physical pain or distress that is associated with starvation. However, individuals with Anorexia feel a sense of contentment or mastery when they have been able to lose weight (1997). Crisp (1995) states “Some anorexics have an occasional experience of exhilaration or even ecstasy when they find that they are managing especially well to maintain their low weight” (p.16).

According to the Mayo Foundation for Medical Education and Research (2014), Anorexia Nervosa can cause the human body to undergo extreme medical conditions. Physical characteristics of this disorder include: dry skin, chapped lips, headaches, fainting, low blood pressure, slow heart rate, and abdominal pain. Unfortunately, this form of self-starvation will eventually lead to death (2014). In fact, Crisp (1995) asserts that anorexics refuse to be categorized as ill. Even after being sent to the hospital several times due to sever medical complications, they will deny that there is a problem that needs to be addressed (1995).
There are also emotional and behavioral characteristics involved with Anorexia. People with this disorder may make excuses in order to avoid eating with family members or friends (Mayo Foundation for Medical Education and Research, 2014).

Bastiani, Rao, Weltzin, and Kaye (1995) acknowledge that individuals with Anorexia Nervosa usually have personality characteristics such as: low self-esteem, difficulty handling conflict, neediness for attention, and a strong desire to please others.

In fact, Bastiani et al. (1995) postulates that one of the main personality traits associated with Anorexia is perfectionism. Individuals who suffer from Anorexia tend to set high, unrealistic goals. Most likely this person learned early on in life that his/her level of achievement is determined by other people's opinions. Therefore, the individual with Anorexia measure his/her self-worth by other people's approval. Perfectionism can foster emotions such as fear of failure, low self-esteem, and regret. Perfectionists also tend to have an “all or nothing” mindset. These individuals are deeply afraid to make mistakes so he/she would rather do nothing than take a chance at doing something the wrong way (Bastiani et al., 1995).

Bastiani et al. (1995) explain that the mind of an anorexic individual also has many cognitive distortions that lead this person to believe that he/she is not good enough despite all efforts. Anorexics have highly critical thoughts that contribute to feelings of shame and doubt. These negative thoughts lead people to behave in self-destructive and self-harming ways (1995). According to the Kerig (2005),

Restrictive eating is maintained through both positive reinforcement resulting from attention from others and a personal sense of achievement, superiority, or
self-mastery, and through negative reinforcement resulting from the avoidance of intense anxiety associated with real or potential weight gain. (p. 29).

Agras (1987) states that Anorexia Nervosa usually beings in early adolescence and can continue throughout adulthood. Individuals between the ages of 12 and 25 years old are the most at risk for this condition. In fact, women are more likely to develop Anorexia than men (1987). The National Association of Anorexia Nervosa and Associated Disorders (2014) has estimated that only 5-15% of people with Anorexia Nervosa are male, while the rest are female. Men are also less likely to seek treatment for this eating disorder because of the stereotype that it’s a “woman’s disease” (2014).

Searching for a single cause of Anorexia Nervosa can be a never-ending task. If Anorexia solely developed because of a young woman’s desire to look like her favorite model, then finding an effective treatment would be a lot easier. Unfortunately the reason why some people develop such a disorder is more complex than one would expect.

Past research indicates that a wide range of factors causes eating disorders. Bryant-Waugh and Lask (2000) point out that Anorexia Nervosa isn’t necessarily about food. It’s an unhealthy way to cope with life’s complex issues. People with this condition not only restrict their diets, but other parts of life as well (2000).

The remainder of this chapter will focus on the familial, social, and interpersonal aspects that take part in the development and maintenance of Anorexia. It is important to view Anorexia Nervosa as a multi-contextual disorder with many different components. Like many other disorders, there is no single cause for the onset of this illness.
Family Systems Perspective

Goldenberg and Goldenberg (2013) explain that structural family therapists believe that it is important to involve the entire family when dealing with a disorder such as Anorexia Nervosa. In fact, these theorists believe that an individual’s symptoms lie within the root of the family’s transactional patterns or ways of interacting with one another (2013). Perhaps it is common for parents to come into therapy and complain that their child is behaving poorly in school or there are too many arguments going on at home. Nichols and Schowartz (2004) believe that therapists want to look beyond the specifics of the problem. The overall goal is to understand how the family has worked together in the past to try and solve this issue (2004). Vetere (2001) indicates that systems therapists focus on the family’s ability to adapt to change and find conflict resolution. It is also important to identify invisible rules, which govern the family’s functioning and roles each household member takes upon (2001). Gehart (2013) states that therapists work with the entire family so that it can be restructured in a way that allows household members to adjust to life’s ongoing developmental and contextual demands.

According to Gehart (2013), Salvador Minuchin is one of the most key influences in structural family therapy. To this day, many therapists use his knowledge and techniques to resolve families’ relational and mental health problems. He believed that families have a powerful impact on an individual’s ability to succeed in treatment (2013). Nichols & Schowartz (2004) believe that individual’s who have been diagnosed with Anorexia Nervosa will most likely heal and become healthier if they know he/she has a safe and supportive environment at home. Gehart (2013) posits that seeing clients alone was not as effective as working with the entire system. Therefore, Minuchin and several
of his colleagues began to develop a treatment model that involved the whole family (2013).

Baker, Minuchin and Rosman (1978) define Anorexia Nervosa as a psychosomatic disorder caused by dysfunctions within a person’s family system. Psychosomatic symptoms are described as bodily symptoms caused by a mental or emotional disturbance (1978).

Baker et al. (1978) state that some of Minuchin’s earliest studies of psychosomatic disorders involved patients who suffered from diabetes. He wanted to understand the relationship between the psyche (mind) and the soma (body). Even though Anorexia and diabetes were completely different illnesses, Minuchin was able to understand that both ailments had common components. Each set of patients had difficulty handling stress and tended to internalize their anger. It was believed that this emotional arousal added a major psychosomatic component to the disease. Even though emotions do not cause the disorder, it could impact the body’s ability to maintain health (1978).

Baker et al. (1978) noted that several changes were made in order to help these patients. Minuchin and his team of psychiatrists started to investigate more about the patient’s home environment. Over time, Minuchin was able to draw a connection between the patient’s emotional stress at home and the severity of his/her symptoms. Therefore, he argued that in order to relieve the patient’s symptoms, he had to work with the entire family in order to create a less chaotic atmosphere. Minuchin was able to identify four similar characteristics amongst these psychosomatic families. He believed
that these patients grew up in households that encountered enmeshment, overprotectiveness, rigidity, and lack of conflict resolution (1978).

According to Baker et al. (1978), Minuchin found that children who suffered from Anorexia tended to live in households with poor boundaries between family members. He used the term “enmeshment” to describe these unhealthy boundaries (1978). Kerig (2005) claims that families with enmeshed boundaries oftentimes lack recognition or acknowledgement for other family members’ need to have personal space. Minuchin stated that enmeshment occurs when family members were so overly-involved in each other’s lives that there was a lack of individuality (Baker et al., 1978). Emotions were also found to be intertwined with one another (Kerig, 2005).

Gehart (2013) indicates that privacy may be seen as “secretive” or prohibited in enmeshed families. In fact, these families tend to demand loyalty at all times, even when it comes to the expense of someone else’s individual needs in the family. For example, parents with poor boundaries may define their self-worth through the son or daughter’s success. Therefore parents with enmeshed boundaries have a difficult time finding their own hobbies and interests. These parents are usually overly involved in a child’s schoolwork, sports, or even friendships (Gehart, 2013). Kerig (2005) further explains that enmeshed families can perceive individuality as a threat.

Gehart (2013) asserts that parents who lack healthy boundaries are usually overprotective and feel the need to know everything that their child is doing. It is common for children who come from enmeshed families to feel that their personal space is not being provided (2013).
Kerig (2005) mentions that enmeshment interferes with a child’s normal development. In fact, these children are usually not given the proper respect or emotional distance that is needed to become independent. “By binding the child in an overly close and dependent relationship, the enmeshed parent creates a psychological unhealthy childrearing environment that interferes with the child’s development of an autonomous self” (Kerig, 2005, p. 10).

On the other hand, Gehart (2013) states that clear boundaries occur when family members simultaneously allow close emotional contact. Each person is allowed to maintain a sense of identity and differentiation while still being able to connect with the family. “Each culture has a unique style of balancing closeness and distance, with different appropriate outward expression of this balance” (Gehart, 2013, p. 126).

Baker et al. (1978) expressed that another common trait amongst psychosomatic families is overprotectiveness, which occurs when there is a high degree of concern over another family member’s welfare. According to the International Association of Eating Disorders Professionals Foundation (2014), overprotective parents may play a role in the development of Anorexia Nervosa. Past studies indicate that anorexic children commonly grew up in households where parents rarely allowed others to care for him/her as infants. In fact, these parents usually became distressed and anxious when there was separation from the children. Even when the child got older, parents would not let him or her spend the night at someone else’s house or stay out late with friends. This sort of overprotectiveness prevented the child from forming his/her own interests or activities outside the family. Therefore, children of psychosomatic families usually lacked their own individuality and authenticity (2014).
Baker et al. (1978) pointed out that parents are not the only ones who have a high need to be overprotective. Children of psychosomatic families also feel a great sense of responsibility to protect the family. It is common for these children to use their symptoms to protect the family from conflict by using the illness as a distraction. This not only works to shield the family from any arguments, but it also causes the illness to persist (1978).

Baker et al. (1978) claimed that the third characteristic of psychosomatic families is rigidity. This term is often used to describe families that have a difficult time adjusting to growth or change within the system. Rigid families are highly committed towards maintaining the family’s sense of continuity and connectedness. These families are highly susceptible to psychosomatic illness due the refusal to give up their family’s sense of cohesiveness (1978).

As previously explained, Anorexia Nervosa is most common amongst young women. The DSM 5 (APA, 2013) states, “Anorexia Nervosa commonly begins during adolescence or young adulthood. It rarely begins before puberty or after age 40” (p. 341).

It is often questioned why most females develop Anorexia during adolescence. Perhaps the reason is due to stressful life events and changes that are associated with puberty. Clopton, Goodheart, and Robert-McComb (2012) acknowledge that adolescence is a period in someone’s life when there is transformation from childhood to adulthood. During adolescence, dramatic changes occur. Adolescents often encounter new social pressures, rapid physical changes, and heightened emotional experiences (2012). Baker et al. (1978) postulates that parents with rigid rules and expectations have an extremely difficult time adjusting to this phase in their child’s life.
According to Balter (2000), one of the psychological changes that an adolescent goes through is his/her need to establish independence and a distinct identity. Baker et al., (1978) explains that in an effectively functioning family, parents usually change the rules as children become older in order to foster a child’s development. For instance, parents may provide children with more responsibilities or privileges by allowing them to stay out late with friends. Children who grow up in rigid families, however, are not granted this individual autonomy. These families are unwilling to explore or discuss issues involving change. “Even when coming into therapy, these families represent themselves as normal and untroubled, except for the one child’s medical problem. They deny any need for change in the family” (1978, p. 31). This denial causes the family’s psychosomatic illness to persist (Baker et al., 1978).

In addition to the psychological changes, there are many physical changes happening to the adolescent’s body. The American Academy of Family Physicians (2001) indicates that an adolescent’s growth spurt will account for approximately 25 percent of a person’s adult height and 50 percent of their adult weight. Moreover, adolescence is a period in someone’s life when his/her reproductive system further matures (2001).

Cavendish (2010) explains that one of the first physical signs of puberty for women is the development of pubic hair and breasts. Shortly afterwards, a woman begins to have changes in her uterus and ovaries. The sequence of pubertal development can vary from one person to another depending on a woman’s environment and biological factors (2010). The American Academy of Family Physicians (2001) believe that eating
disorders such as Anorexia Nervosa can delay puberty and actually have a devastating impact on a woman’s reproductive system.

The Academy of Family Physicians (2001) points out that women who have been diagnosed with Anorexia Nervosa have an increased chance at developing amenorrhea, a medical term used to describe abnormalities in a woman’s menstrual cycle. With so many physical changes happening, nutrition plays a key role in aiding the proper growth and development to the human body. Women who restrict the body’s caloric intake will often times have trouble maintaining a healthy menstrual cycle. The body’s lack of nutrients causes her estrogen levels to drop and therefore ovulation will not occur (2001).

In addition to the female’s inability to ovulate, malnutrition can also affect other physical characteristics as well. According to Cooper and Stein (1992), females who have an eating disorder may fail to develop breasts as a result of her body’s malnutrition.

Clopton, Goodheart, and Robert-McComb (2012) state that women with eating disorders may experience puberty with a negative connotation. Unconsciously she associates puberty as being shameful and disgusting (2012). Neilsen (2012) reveals that parents also tend to disapprove their daughter becoming a sexually mature young woman. Consequently the child may stop eating in order to regain her “little girl” appearance (2012). Rigid families are therefore able to unconsciously avoid change through the child’s illness (Baker et al., 1978).

Baker et al. (1978) reported that psychosomatic families are also characterized by the inability to have conflict resolution. Conflict is often avoided by finding ways to detour confrontation and prevent any sort of acknowledgement that there is an issue. For example, one person may leave the house if another person tries to discuss a previous
argument. Most psychosomatic families have a high need to maintain harmony by denying the fact that there is a problem. Other times, psychosomatic families will disagree openly about a topic, but constantly interrupt one another or change the conversation. Family members find ways to diffuse issues through distractions or shifting positions. Children learn at a young age that conflict cannot be confronted or even negotiated within the family. Unlike families that have ways of resolving conflict, psychosomatic families are not able to disagree with one another (1978).

Over time psychotherapists such as Baker et al. (1978) were able to identify a fifth characteristic to psychosomatic families. It became evident that a child’s illness continued to persist due to his/her involvement in parental conflict. Parents of psychosomatic families are frequently unable to directly deal with their marital problems so children are left to choose sides. These children also play the role of being a mediator between the two parents (1978). Neilsen (2012) believes that an anorexic’s illness is usually the “glue” that holds the marriage together. Baker et al. (1978) identified three techniques these families use to avoid conflict between parents: triangulation, parent-child coalition, and detouring (1978).

**Conflict avoidance techniques.** Baker et al. (1978) contends that the first technique used in order to avoid parental conflict is triangulation. During this situation, both parents are in conflict with one another and the child is forced to choose sides. Therefore the child is allied with one parent and against the other. This technique causes tension between the child and the parents. Triangulation is reinforced by not allowing the child to express him/her self without siding with one parent. It also puts children in an unfair and uncomfortable position. Parents usually contribute to the situation by imposing
judgment or disappointment on the child for not picking a side. Triangulation is just one technique dysfunctional families use to avoid direct communication with one another (1978).

The next technique identified by Baker et al. (1978) that psychosomatic families use to avoid conflict is parent child coalitions. In fact, parent-child coalitions happen as a direct result of triangulation. Over time children tend to move into a permanent alliance with one parent and exclude the other. Families that have healthy boundaries on the other hand, have a stronger parental system that will not allow children to be a part of these conflicts (1978).

According to Baker et al. (1978), the last technique psychosomatic families use to escape parental conflict is detouring. During this situation, the parental system is completely united. Children are oftentimes blamed or ridiculed for problems within the marital system when parents do not want to directly deal with the issue. Detouring happens on an unconscious level. Often psychosomatic families will deny or be completely unaware that this issue exists (1978).

Baker et al. (1978) state that detouring causes the child to be labeled as the identified patient or “problem child” in the family. Therapists use the term identified patient to describe a person who has been unconsciously selected to act out the family’s inner conflicts. Instead of the family directly dealing with the conflict, the identified patient uses his/her symptoms to distract the family from directly dealing with the issue (1978).

Baker et al. (1978) claims that the identified patient is selected because he/she is the most sensitive or vulnerable person in the family. These people are usually more
intuitive about picking up social cues or other family member’s emotions. Unconsciously the identified patient feels the need to protect the family from dealing with the conflicts, disappointments, and struggles that are too painful for other members of the family to internalize (1978).

Baker et al. (1978) classified anorexic children as the identified patient or “IP” in the family. Minuchin’s goal was to help the family members understand how children with Anorexia develop and maintain their illness as a result of the family’s unwillingness to directly deal with the problem. Instead of specifically focusing on the behaviors of the identified patient, the researchers provided insight as to how the entire system functioned and the roles each member takes upon (1978).

Goldenberg and Goldenberg (2013) assert that systems therapists believe that having an identified patient in the family leads to scapegoating. Scapegoating is defined as singling out or excluding one person from the family. The scapegoat often feels insecure and not liked by other members of the family (2013). Yahav and Sharlin (2002) mention that the family scapegoat may also be commonly called “the black sheep” in the family. In extremely dysfunctional families, parents will favor one child while criticize the other (2002).

According Boss, Doherty, LaRossa, Schumm, and Steinmetz (2009), scapegoating causes family members to be disengaged with one another due to poorly managed and unresolved issues. Children who have been selected to be the family’s scapegoat usually have an emotional or physical problem that detours the family away from actually dealing with the issue. For instance, when a family is having financial problems the parents may blame the child that places the most financial stress on the
family (2009). Grey (2009) explain that the role of the scapegoat will continue to persist until each family member is willing to take full ownership of his/her problem.

Bake et al. (1978) report that Minuchin created family systems therapy to promote healthy, functioning families. He believed that every human being’s identity largely depends on the validation of a reference group. In fact, the most important reference group he describes is a person’s family. This validation and support is required in order to develop a strong sense of autonomy. Children are able to strive and grow up to be independent adults when they are raised in a healthy environment (1978).

Baker et al. (1978) argues that Salvador Minuchin made a tremendous impact to the way health professionals understand psychological and physical ailments. He developed the idea of using family systems therapy to better understand the connection between the body and mind. Minuchin believed that families had an enormous impact on one’s everyday functioning. Throughout his career he worked with couples and families to develop a treatment method for dealing with complex mental disorders. He emphasized the importance of creating positive interactive patterns within the family system in order to maintain good health. Over the years family systems therapy has evolved, but therapists still use Minuchin’s theoretical foundation of family systems therapy (1978).

Socio-Cultural Influences

The socio-culture theory of psychology believes that the media, peers, and parents influence an individual’s behaviors. Researchers have investigated the sociocultural influences that shape the onset and maintenance of eating disorders.
According to Choate (2013), hidden messages about body appearance and the pressure to be thin may increase an individual’s likelihood of developing Anorexia. The media advertises thinness through television, magazines, Internet, and movies. People tend place a high value upon appearance in today’s society. Women are supposed to be thin and sexy, while men are meant to be lean and muscular (2013).

In fact, Choate (2013) indicates that most Americans watch television on a daily basis. The average 8 year old watches 1 hour and 44 minutes of television daily, while teenagers on average watch 1.5 hours per day. Exposure to continuous messages regarding body image, especially if they start at a young age, may lead people to think that the content being portrayed is normal (2013).

Choate (2013) acknowledges the fact that Americans are being exposed to television at a very young age, some as young as infancy. Hammond (2006) states that movies such as Cinderella and The Little Mermaid portray beautiful, thin women to little girls. Unfortunately, most small children are not able to distinguish the difference between a realistic body image with an artificial cartoon that idealizes thinness. In fact, children are even more susceptible to believing the media’s unrealistic messages regarding body image than a grown adult (2006).

Nichter (2000) believes that young women are also getting ideas about what defines beauty through fashion magazines and billboard advertisements. Statistics show that 50% of young women are regular readers of fashion magazines such as Glamor or Seventeen. (2000). Ruggiero (2003) states that 22.5% of these advertisements published in magazines encouraged readers to lose weight and obtain an ideal image. This mostly targeted women between the ages of 14-18 years old, from upper-middle class
backgrounds (2003). Choate (2013) points out that women are being encouraged to buy diet products, try new exercise programs, and even inject themselves with Botox. These advertisements are giving young women the message that the ideal standard of beauty is not just a fantasy, but an attainable reality for those who are willing to invest enough time, energy, and money (2013). Nichter (2000) explains that when women are constantly exposed to advertisements with highly attractive models, they are more likely to become self-conscious and overly critical of their own physical appearance.

According to Hammond (2006), the media’s standards regarding body image are not only unrealistic but also unhealthy for most of people to obtain. The average American model is approximately 5’11 and weighs 117 pounds. In comparison, the average American woman is approximately 5’4 and weighs 140 pounds. Not only are models thinner than most women, but doctors would also consider them to be underweight (2006).

Nichter (2000) has noted that even before girls reach adolescence, they are given messages that portray an unrealistic body image. Barbie is considered to be the most popular doll for young girls in America. In fact, it accounts for 1.9 billion dollars in annual sales. So many young girls are being exposed to this idea that in order to popular and beautiful you a woman must have thin figure. The media’s focus on slender women not only dismisses the diversity of female shapes but it erases overweight women from societal vision completely (2000).

Nechter (2000) argues that women are being seen as sexual objects that are only to be looked at for men’s pleasure. The media advertises to young women that the “road to happiness” is attracting men by physically altering her appearance. The media wants
women to be able to measure their self-worth through their ability to seduce men and be physically appealing. The media has a powerful effect on young women today and their perceptions of the ideal body image (2000).

According to Argas (2010), parental influence is known to be one of the strongest predictors in the development of an eating disorder. Choate (2013) states that it is common for children to fear disappointing their parents by being overweight. Girls are more likely than boys to receive negative comments from their parents regarding body image (2013). Agras (2010) explains that when children have added pressure from family members it affects their self-esteem and creates even more dissatisfaction with their body appearance.

Nielsen (2012) discloses the fact that fathers have a powerful influence on a young woman’s self-esteem. Fathers who criticize daughters for gaining weight or idealizes thin women maybe reinforcing a cultural belief that skinny women are beautiful. On the other hand, overweight women are considered ugly and unattractive. Unconsciously a daughter may feel rejected and unloved by her father if she gains weight. In order to have respect and acceptance she believes that she must be thin (2012).

Nielsen (2012) recognizes that Anorexia Nervosa mostly occurs in upper-income, well-educated families. The researcher states, ”Because many anorexics’ fathers are well-educated, successful men, these daughters may presume they are not measuring up to their fathers’ expectation” (p. 95). These young women seek perfection in order to please and gain acceptance from their fathers. Unfortunately this perfection takes place in a life threatening disorder (2012).
Choate (2013) reports that mothers can also put added pressure on young girls to maintain a thin appearance by sending underlying messages that she may not be consciously aware of. Mothers who engage in dieting or say negative comments about their own bodies could be giving a child the idea that being fat is unacceptable (2013). Studies have indicated that girls as young as 5 years old are more likely to have concerns regarding weight if they grew up in a household with a mother who was also concerned about weight (Agras, 2010).

Choate (2013) explains that when parents restrict or control their child’s diet it could contribute to the onset of an eating disorder. This is especially a problem for parents who reward a child’s positive behavior with food (2013).

Choate (2013) mentions that children’s peers are also known to influence the onset of an eating disorder. It is normal for children to observe and watch other people’s behavior. Children oftentimes just want to fit in and be accepted by their peers. According to Choate, children are deeply afraid of being teased or made fun of by other kids therefore there is a tremendous amount pressure not to be overweight (2013). Hammond (2006) noted that over the past 20 years the importance of body image has increased. One study revealed that 30% of elementary school girls were starting to diet (2006).

According to Nichter (2000), girls will often engage in conversations with friends about body weight. “Fat talk” happens all the time in locker rooms, schoolyards, or even at work parties with older adults. A woman engages in fat talk when she complains about the size of her butt or her legs compared to another girl. This is a way for women to call attention to their imperfections before anyone else does (2000).
Hammond (2006) states that women will go through extreme dieting methods just to gain love and acceptance from others. Being thin is perceived as being attractive, successful, and in control. A young girl’s self-worth can be determined by her ability to be thin (2006).

Parent-Child Attachment

There is a basic assumption in the field of psychology that the quality of our relationships can have a significant impact on our mental health. According to Galperin, Gleiser and Schwartz (2009), past research has indicated that there is a link between parent-child attachment and eating disorders. Attachment theory originated from the work of John Bowlby. Bowlby (1979) defines attachment as an affectional bond between a child and his/her primary caregiver. Elgin & Pritchard (2006) declare that it is a biological and innate characteristic for an infant’s desire to attach to his/her primary caregiver. Galperin et al. (2009) noted that attachment is an essential element of survival. It provides an individual with the necessary protection, comfort, and security to explore the world. Children need a stronger, wiser caregiver to provide them with the necessary guidance and care (2009).

Galperin et al., (2009) suggest that an individual’s earliest relationships in life have a profound effect on his/her ability to feel loved and accepted by others. Children who grow up with a secure attachment describe receiving consistent care from their parents. In fact, these children usually have a strong sense of self and their relationships with other people. Caregivers will often provide assistance on helping the child regulate intense negative effects such as fear, sadness, and anger. Securely attached individuals are also more likely to have open, honest, and equal relationships (2009). Bowlby (1979)
believed that adults who have a secure sense of attachment grew up with consistent comfort and support from his/her primary caregiver.

According to Galperine et al. (2009), when there is a disruption in the child’s attachment toward a caregiver, the effects could be devastating. Children with an insecure attachment towards their primary caregiver are known to have an internal capability to suppress emotions. Most likely the parent rejected or dismissed their emotions and therefore did not perceive the primary caregiver as dependable source of comfort and protection. Children with an insecure attachment often times feel abandoned, overwhelmed, and alone. Children with insecure attachments are described as having a longing to fulfill his/her inner emptiness. Numerous studies have found that insecurely attached children are more likely to encounter developmental problems such as the inability to develop autonomy and form a positive self-image compared to children with secure attachment towards a primary caregiver. Children with insecure attachments long for their parent’s warmth and support, which is unfortunately not given in a consistent manner (2009).

Galperin et al. (2009) indicates that children who grow up with an insecure attachment are at greater risk of the development and maintenance of an eating disorder. Hilda Bruch was one of the first to suggest that a child’s attachment towards his/her plays a central role in the development of Anorexia Nervosa. She believed that eating disorders are traced back to ruptures between the parent-child attachment. Children who aren’t provided with a means of security are more likely to develop an eating disorder as a way of coping with life’s unpredictability and everyday stressors. Anorexic children are
“hungry” for the parent’s affection, while at the same time feel hyper-anxious about being rejected (2009).

Aronson (1993) argues that children suffering from Anorexia most likely grew up with a self-centered or narcissistic mother who is unable to recognize her child’s emotional needs. This parent would oftentimes dismiss or neglect the child in order to cope with her own insecurities. Narcissistic mothers are often described as controlling, intrusive, and overprotective of her children. They frequently prevent their child from engaging in life’s pleasures that are separate from them. In return, the child’s development of Anorexia might be a means of separating his/her self from the parent (1993).

Aronson (1993) states that children raised a with narcissistic parent become so preoccupied with taking care of the caregiver’s emotional needs that their own needs are neglected. According to Galperin et al. (2009), these children become overly focused on not disappointing their caregivers. Brush believed that the narcissistic mother does not see her child as a separate individual, but rather an extension of herself. Children are oftentimes dismissed or punished for the desire to recognize their own emotional needs (2009). Dr. Nina Brown is a well-known author who published many books about children growing up narcissistic parents. According to Brown (2008), children who grow up with a narcissistic mother are able to reveal their real selves without being rejected.

Brown (2008) argues that narcissistic mothers are self-absorbed and lacked empathy for their child. Narcissistic mothers are known to make devaluing comments or remarks towards the child if he/she does not comply towards their own needs. Children are labeled as selfish or unreasonable when they reach out to the caregiver for emotional
support. In addition, these parents constantly blame others for the mistakes or misfortunes that have occurred. Children are therefore put in a bad position to sacrifice their true selves in order to maintain loyalty and attachment towards the parent (2009).

Brown (2008) suggests that children who grew up with a mother developed the idea that they must be perfect and could not reveal any mistakes. A child’s means of self-worth was determined by his/her ability to please the mother. Therefore children were expected to be neat, clean, and quiet at all times. This sense of perfectionism triggers feelings of unworthiness and being unloved when the child exposes his/her flaws to the parent. It is common for narcissistic mothers to make unfair comparisons with siblings and other people regarding their accomplishments and achievements. Perfectionism leads to unhealthy and destructive behavior that paralyzes a person’s ability to love his/her self (2008). This may be why anorexic children engage in self-destructive behavior that puts his/her life at risk.

Leonard (1982) studied the effects of parent-child attachment. She argues that it’s important for young women to grow up with a strong father figure. In fact, women with an insecure attachment towards their father are more likely to have low self esteem, a lack of confidence, inability to for lasting relationships, and trouble functioning in the real world. Women who have been wounded by a bad relationship towards their fathers often have a poor image towards men in general. Leonard states, “As a daughter grows up, her emotional and spiritual growth is deeply affected by her relationship to her father. He is the first masculine figure in her life and a prime shaper of the way she relates to the masculine side of herself and ultimately to men” (Leonard, 1982, pg. 11).
According to Leonard (1982), women with an insecure attachment towards their father can often feel betrayed and disappointed by his actions. It is common for women to repress the hurt and anger that they feel towards their father. Growing up these women might have seen their father act out in rage or anger quite frequently. Over time the woman tends to label this intense amount of anger as unacceptable or crazy. As a result she tends to suppress any anger or frustrations towards her father in order to prevent herself from judging her own actions (1982).

Leonard (1982) states that these women most likely grew up in an environment where they felt unprotected from their dad’s anger and rage. As they a result developed their own defense mechanism by working hard to please their father in order to prevent him from escalating into further rage. Subconsciously they organized the idea that in order to protect themselves and keep peace within the family, they must suppress their own emotions (1982).

Leonard (1982) argues that these unresolved feelings can often turn into the form of somatic symptoms. According to Galperin et al. (2009), eating disorders are used as a survival technique or strategy to cope with the parent’s inability to identify or articulated the child’s emotional state. Children unconsciously turn to food as a way to avoid anxiety or painful feelings towards her mother or father. Unfortunately, this means of survival does not fix his/her problem, but acts as if a Band-Aid or quick fixes for sever problems (2009).

Galperin et al. (2009) explains that such patterns of insecure attachment linger throughout a person’s lifespan. Patterns of attachment are the building blocks of emotional regulation. A child’s quality of attachment is determined by the caregiver’s
ability to be empathically attuned to his/her child’s needs. However, if the mother or father is unable to provide warmth and comfort the child, he/she is most likely to turn inward or find other means of self-soothing uncomfortable and painful emotions (2009).

**Object Relations Theory**

According to Ainsworth (1969), object relations theory stems from the psychoanalytic perspective that emphasizes an infant’s need for contact and connection with others. The term object is commonly referred to as a person; which is usually the infant’s primary caregiver. Theorists use the term relations to describe the bond between the infant and his/her caregiver. In fact, infants are fully dependent upon his/her caregiver as an essential means of survival (Ainsworth, 1969).

Johnson (1991) noted that the connection to his/her primary caregiver is complex. The child’s perception of the object is determined by three factors: (1) the quality of the relationship to his/her caregiver, (2) the child’s innate temperament, (3) the way in which the child experiences and understands his/her world (1991).

Johnson (1991) suggest that object relations theorists are interested in the quality of these interpersonal relationships and how it forms a person’s inner images of the self. Children essentially want and need to develop meaningful relationships with others in order to feel a sense of belonging. Human beings are motivated by their desire to establish and maintain relationships. Therefore, theorists believe that “mental disturbances” are actually a result of disturbances in interpersonal relationships with others. The patient does not necessarily suffer from “symptoms,” but from “contact disturbances.” Many theorists shift their focus away from a patient’s mental illness and center the attention on the individual’s inability to sustain fulfilling relationships (1991).
Sands (2003) claim that object relations theorists view eating disorders as a way of filling in the missing bond between the parent and child. Early on the anorexic patient learns that the primary caregiver would not be able to provide him/her with the warmth and support that is needed to soothe one’s self from distress (2003). Theorists therefore believe that the patient’s symptoms are construed in terms of one’s representation of human relationships (Johnson, 1991).

Sands (2003) contends that patients with Anorexia learn early on that they cannot seek emotional support from the primary caregiver when their lives are messy and out of control. In fact, the caregiver’s failure to attune to his/her emotional needs has leave this person feeling rejected, alone and abandoned. Theorists believe that Anorexia serves as a way of protecting the child from these painful emotions (2003).

Sands (2003) reveals that the anorexic patient fears dependency. This individual would rather use his/her body as a means to seek self-regulation than to be disappointed by the caregiver’s failure to be empathic towards his/her needs. Patients with Anorexia are just as afraid of being dependent upon others just as they are with food. Unconsciously the individual believes that he/she is strong, admirable, and self-sufficient. Although on the inside, this person is really just suppressing the desire for love and connection towards others (2003).

Sands (2003) describes food is described as a “love-affair” for the anorexic individual. In fact, food acts as a substitute for the self-object or also known her primary caregiver. Anorexics may have internal thoughts such as “I am fat” or “I don’t need food to survive” but they are really just denying the desire for affection from the caregiver (2003).
Johnson (1991) states that over time the anorexic patient fears food just the same as he/she would fear connection to others. In the past this person experiences intimate relationships with others as traumatic. Patients with Anorexia often grew up with parents who had poor boundaries and inappropriate ways of showing affection. Many times parents engaged in inappropriate sexual activities such as exposing the child to pornographic movies. The patient’s desire to decline food may also be interpreted as the desire to decline emotional connection from her parents (1991).

Johnson (1991) believes that the child is often put into a dangerous position. She now interprets the relationship(s) with the primary caregiver as unsafe. Therefore, the child is more inclined to hide his/her true self than turn towards others for emotional affection. Self-starvation is just an act of rebellion, anger, and rage towards the parent(s). The child learns that it is safer to isolate herself and hide emotions rather than seek emotional support from others (1991).

According to Garner and Garfinkel (1997), anorexic patients are unable to develop a secure sense of self due to these disturbed relationships. The individual is unable to form a healthy identity and connection towards others. Therefore, patients are usually developmentally immature and have low self-esteem. Patients are often described as an “empty shell” because of his/her inability to describe emotions (1997). Bonney and Chelton (1987) state that anorexic patients are left feeling anxious and fragmented.

Instead of dealing with the painful feelings of worthlessness and rejection, anorexic individuals learn that they must turn towards another substitute. Anorexia
Nervosa prevents individuals from experiencing love and connection towards others, let alone themselves.

**Summary**

It is important for therapists to consider the different factors that may contribute to the onset of Anorexia Nervosa. Eating disorders can arise from many different factors. A person’s family life, interpersonal relationships, and his/her surrounding environment are just a few elements to consider when working with clients with Anorexia. Perhaps there may be other reasons why individuals develop Anorexia. Therefore, therapists should remain open-minded and consider that there are multiple theories that explain why individuals develop this disorder.
Chapter 3

Project Audience and Implementation Factors

Introduction

This chapter will discuss the development of a workshop that correlates with the literature of this project. It will also discuss the type of audience that would benefit most from the workshop. In addition, it will also clarify what type of professional qualifications is needed by the presenter and the ideal environment for the workshop. Finally, a brief outline of the workshop will be included at the end of this chapter.

Development of Project

The beginning phase of developing this project consisted of a thorough review of current literature and educational websites in order to gather information about the symptoms, characteristics, and prevalence of Anorexia Nervosa. However, most of the research focuses on different therapeutic models that theorized how Anorexia Nervosa developed in young adults. These therapeutic models focus on an individual’s home environment, interpersonal relationships, as well as social surroundings. The last part of this project consists of a PowerPoint presentation that included all the information that was previously researched.

Intended Audience

This project is intended to be presented to professionals in the field of Marriage and Family Therapy (MFT). Specifically for MFT trainees or interns that are working towards licensure. Professors may also use this project to teach students about the information that is presented during this workshop.
Professional Qualifications

The presenter of this workshop must have at least a master’s degree in counseling- ideally in the field of Marriage and Family Therapy. The presenter of this workshop does not have to be a licensed professional. In fact, he/she can be a trainee or intern that is still gaining hours of experience.

Environment and Equipment

This workshop requires a large quite room, such as a lecture hall or conference room. The room needs to large enough to accommodate 30 or more people. The necessary equipment for this workshop includes: a laptop, projector, screen, and adaptors to the set up the presentation off a PowerPoint slide show.

The presented material will also be printed out and handed out to the attendants of this workshop. This will not only provide the attendants with a space to take notes on but will allow them to keep the information for further use.

The estimated amount of time for this workshop is approximately one and a half to two hours. It is recommended that the presenter of this workshop provides a 15-minute break half way through the presentation as well as to allow an additional 15 minutes at the end for questions.

Project Outline:

A.) Introduction

B.) Purpose of the Workshop

C.) Defining Anorexia Nervosa

1.) Behavioral Characteristics

2.) Personality Characteristics
3.) Physical Symptoms

4.) Prevalence

D.) Family Systems Perspective

1.) Key Elements in Family Systems Therapy

2.) The Work of Salvador Minuchin

3.) Psychosomatic Disorders

4.) Characteristics of Psychosomatic Families
   a.) Enmeshment
   b.) Overprotection
   c.) Rigidity
   d.) Lack of Conflict Resolution

E.) Socio-Cultural Influence

1.) The Media’s Hidden Messages Regarding Body Image

2.) Exposing Young Children to the Media

3.) Unrealistic Standards

4.) Parental Influences

5.) Peer Influences

F.) Parent-Child Attachment

1.) Defining Attachment
   a.) Affections on Relationships
   b.) Secure Attachment
   c.) Insecure Attachment

2.) Attachment and Eating Disorders
a.) The Narcissistic Mother

b.) Insecure Attachment With the Father

G.) Object Relations Theory

1.) Understanding Object Relations Theory
   a.) Perception of the Object
   b.) Perception of the Self

2.) Object Relations and Mental Illnesses
   a.) Empathic Failures
   b.) Missing Bond
   c.) Fear of Dependency
   d.) Substituting the Parent for Food
   e.) Using Food as a Form of Protection
   f.) Using Food to Mask Emotions
   g.) The Fear of Food

H.) Summary

I.) Questions
Chapter 4

Conclusion and Further Work

This chapter will provide a brief summer of the previous chapters discussed during this project. It will also provide recommendations for future work on this topic, as well as a conclusion. The final portion of this project will provide of a PowerPoint presentation for professionals in this field to use in order to enhance his/her understanding about working with individuals suffering from Anorexia Nervosa.

Summary

It is important for therapists to understand the complexity of eating disorders when working with clients that are suffering from illnesses such as Anorexia Nervosa. Past research indicates that Anorexia Nervosa is a multi-contextual disorder that is caused from numerous factors. Every person is unique and therefore there will not be a single cause for the onset and development of this disorder. I developed this project in hopes that it will inform other therapists in the field about the familial, cultural, and interpersonal factors that trigger the development of this illness.

Recommendations for Future Work

There is a great need for further research about the root causes behind Anorexia Nervosa. As I was conducting the literature review I came across other theories that also provided an explanation why individuals develop this disorder. Some researchers suggest that Anorexia Nervosa is caused by physiological dysfunctions in the brain. Although, the research I found provided vague, unclear explanations and therefore I did not include this information in the literature review. It seemed to be that there wasn’t a sufficient amount
of evidence that would provide readers with a clear understanding behind this theory. Perhaps there needs to be further research in order to fully understand this concept.

**Conclusion**

Anorexia Nervosa is a life threatening disorder that leaves individuals and families feeling hopeless. Often times, it is up to Marriage and Family Therapists or other mental health professionals in this field to provide hope and treatment for these individuals/families. Hopefully this project inspires many other professionals in this field to become more aware about the root causes behind Anorexia Nervosa.
References


Understanding Anorexia Nervosa from a Multi-Contextual Perspective

Ariel Black
Cal State University Northridge

INTRODUCTION

• Research indicates that 30 million people, regardless of an individual’s age and gender, suffer from some sort of eating disorder in the United States (National Association of Anorexia Nervosa and Associated Disorders, 2014).

• In order to prevent anorexia from increasing in its popularity, it is important to understand the reasons for the onset and maintenance of this disorder.
PURPOSE OF THE WORKSHOP

• The purpose of this workshop is to inform counselors in the field of Marriage and Family Therapy about the reasons for developing Anorexia Nervosa.

• This workshop is designed to explain the different theoretical perspectives that explain why people develop eating disorders. It will address the familial, social, and interpersonal reasons that theorist believe causes the onset of Anorexia.

DEFINING ANOREXIA NERVOSA
DSM DEFINITION:

• According to the Diagnostic and Statistical Manual of Mental Disorders an individual that suffers from Anorexia Nervosa has an intense pathological fear of becoming fat (DSM 5, APA, 2013).

• Anorexic patients will restrict his/her caloric intake or misuse substances such as laxatives, directics, or even enemas in order to lose weight (DSM 5, APA, 2013).

Behavioral Characteristics

• Excessive exercise

• Making excuses in order to avoid eating with family members or friends

• Social withdraw

• Denial of hunger

• Lying about how much food has been eating

(From Mayo Foundation for Medical Education and Research, 2014)
Slide 7

**Personality Characteristics**

- Low self-esteem
- Difficulty handling conflict
- Neediness for attention
- Desire to please others
- Perfectionism

(Bastiani, Rao, Weltzin, & Kaye, 1995)

Slide 8

**Physical Symptoms**

Anorexia Nervosa can cause the human body to undergo extreme medical conditions including:

- Dry Skin
- Chapped Lips
- Headaches
- Low Blood Pressure
- Abdominal Pain
- Slow heart rate
- Death

(Mayo Foundation for Medical Education and Research, 2014)
Prevalence

◆ Anorexia Nervosa usually begins in early adolescence and continues on throughout adulthood. Individuals between the ages of 12 and 25 years old are the most at risk for this condition (Agras, 1987).

◆ The National Association of Anorexia Nervosa and Associated Disorders (2014) has estimated that only 5-15% of people with Anorexia Nervosa are male, while the rest are female.

FAMILY SYSTEMS PERSPECTIVE
KEY ELEMENTS IN FAMILY SYSTEMS THERAPY

• Structural therapists work with the entire family so that it can be restructured in a way that allows household members to adjust to life’s ongoing developmental and contextual demands (Gehart, 2013).

• Structural therapists believe that it is important to identify invisible rules, which govern the family’s functioning and roles each household member takes upon (Vetere, 2001).

KEY ELEMENTS IN FAMILY SYSTEMS THERAPY CONTINUED

• The overall goal is to understand how the family has worked together in the past to try and resolve conflict (Nichols & Schowartz, 2004).
The Work of Salvador Minuchin

- Salvador Minuchin is one of the most key influences in structural family therapy (Gehart, 2013).

- He believed an individual’s symptoms lie within the root of the family’s transactional patterns or ways of interacting with one another (Goldenberg & Goldenberg, 2013).

Psychosomatic Disorders

- Salvador Minuchin defines Anorexia Nervosa as a psychosomatic disorder caused by dysfunctions within a person’s family system (Goldenberg & Goldenberg, 2013).

- Psychosomatic symptoms are described as bodily symptoms caused by a mental or emotional disturbance (Baker, Minuchin & Rosman, 1978).
Psychosomatic Disorders Continued

Minuchin believed that patients with Anorexia lived in a highly stressful environment that caused the onset and maintenance of their disorder (Baker, Minuchin & Rosman, 1978).

Characteristics of Psychosomatic Families

Salvador Minuchin was able distinguish four characteristics of psychosomatic families:

• Enmeshment
• Overprotection
• Rigidity
• Lack of Conflict Resolution

(Baker et al., 1978)
Enmeshment

- Minuchin found that children that suffered from Anorexia tended to live in households with poor boundaries between family members (Baker, Minuchin & Rosman, 1978).

- Minuchin stated that enmeshment occurs when family members are overly involved in each other's lives and there is a lack of individuality (Baker, Minuchin & Rosman, 1978).

- Privacy may be seen as "secretive" or prohibited in enmeshed families (Kerig, 2005).

Enmeshment Continued

- Children that grow up in enmeshed families are not given the proper respect or emotional distance that is needed to mature and become independent (Gehart, 2013).

- "By binding the child in an overly close and dependent relationship, the enmeshed parent creates a psychological unhealthy childrearing environment that interferes with the child's development of an autonomous self" (Kerg, 2005, p. 10).
Overprotection

• Overprotection occurs when there is a high degree of concern over a family member’s welfare (International Association of Eating Disorders Professionals Foundation, 2014).

• Past studies indicate that anorexic children grew up in families were parents rarely allowed others to care for him/her (International Association of Eating Disorders Professionals Foundation, 2014).

• Overprotection causes children to lack his/her own individuality and authenticity (Gehart, 2014).

OVERPROTECTION CONT.

• Children of psychosomatic families also feel a great sense of responsibility to protect the family. Children will use their symptoms to distract family members from conflict-causing the illness to persist.

(Baker et al., 1978)
Rigidity

- Rigidity often used to describe families that have a difficult time adjusting to growth or change within the system.

- Rigid families are highly committed towards maintaining the family’s sense of continuity and connectedness.

(Baker et al., 1978)

Rigidity Continued

- Adolescents is a period in someone’s life when the transformation from childhood to an adult occurs. Parents with rigid rules and expectations have an extremely difficult time adjusting to this phase in their child’s life.

- Children who grew up in rigid families are not granted the individual autonomy or space.

- In fact, These families are also unwilling to explore or discuss issues involving change.

(Baker et al., 1978)
Lack of Conflict Resolution

- Most psychosomatic families have a high need to maintain harmony.

- Conflict is often avoided by finding ways to detour confrontation and prevents any sort of acknowledgement that there is an issue.

- Family members find ways to diffuse issues through distractions or shifting positions.

(Baker et al., 1978)

Avoiding Conflict Within the Marital System

- Parents of psychosomatic families are frequently unable to directly deal with their marital conflict.

- Unfortunately this leaves children to take upon the role of being the mediator between the two parents.

(Baker et al., 1978)
TECHNIQUES USED TO AVOID MARITAL CONFLICT

Therapists were able to identify three techniques that were use to avoid marital conflict:

- Triangulation
- Parent-child coalition
- Detouring

(Baker et al., 1978)

TRIANGULATION

- During this situation both parents are in conflict with one another and the child is forced to choose sides.

- Therefore the child is allied with one parent and against the other.

- This technique causes tension between the child and the parents. Triangulation is reinforced by not allowing the child to express their self without siding with one parent.

(Baker et al., 1978)
PARENT CHILD COALITIONS

- Parent-child coalitions happen as a direct result of triangulation. Over time children tend to move into a permanent alliance with one parent and exclude the other.

- Families that have healthy boundaries on the other hand, have a stronger parental system that will not allow children to be a part of these conflicts.

(Baker et al., 1978)

Detouring

- During this situation the parental system is completely united.

- Children are often times blamed or ridiculed for problems within the marital system.

(Baker et al., 1978)
The Identified Patient

• Detouring causes children to be labeled as the identified patient or “problem child” in the family.

• Therapists use the term-identified patient to describe a person who has been unconsciously selected to act out the family’s inner conflicts.

• Instead of the family directly dealing with the conflict, the identified patient uses their symptoms to distract the family from directly dealing with the issue.

  (Baker et al., 1978)

The Identified Patient Cont.

• Minuchin classified anorexic children as the identified patient or “IP” in the family.

• His goal was to help the family members understand how children with anorexia developed and maintained an illness as a result of the family’s unwillingness to directly deal with the problem.

• Instead of specifically focusing on the behaviors of the identified patient, he provided insight as to how the entire system functioned and the roles each member takes upon.

  (Baker et al, 1978)
SCAPEGOATING

• Systems therapists believe that having an identified patient in the family leads to scapegoating. This is defined as singling out or excluding one person from the entire system (Goldenberg et al., 2013).

• This member may also be called “the black sheep” of the family. This individual often feels insecure and not liked by other household members (Yahav & Sharlin, 2002).

FAMILY SYSTEMS CONCLUDED

• Salvador Minuchin created family systems therapy to promote healthy, functioning families.

• He believed that every human being’s identity largely depends on the validation of a strong reference group such as their family.

(Bake et al., 1978)
SOCIO-CULTURAL INFLUENCES

• The socio-culture theory of psychology believes that the media, peers, and parents influence an individual's behaviors.

• Researchers have investigated the sociocultural influences that shape the onset and maintenance of eating disorders.
THE MEDIA’S HIDDEN MESSAGES REGARDING BODY IMAGE

- Hidden messages about body appearance and the pressure to be thin are advertised through television, magazines, Internet, and movies.

- People place a high value upon appearance in today’s society.

- Women are supposed to be thin and sexy, while men are meant to be lean and muscular.

(Choate, 2013)

EXPOSING YOUNG CHILDREN TO THE MEDIA

- Research indicates that Americans are being exposed to television as young as infancy.

- Exposure to continuous messages regarding body image, especially if the child starts at a young age, may lead people to think that the content being portrayed is normal.

(Choate, 2013)
EXPOSING YOUNG CHILDREN TO THE MEDIA CONTINUED

- Barbie is considered to be the most popular doll for young girls in America. In fact, it accounts for 1.9 billion dollars in annual sales (Nichter, 2000).

- Unfortunately, most small children are not able to distinguish the difference between a realistic body image with an artificial doll that idealizes thinness (Hammond, 2006).

UNREALISTIC STANDARDS

- Unfortunately, the media’s standards regarding body image are not only unrealistic but also unhealthy for most of people to obtain.

- The average American model is approximately 5’11 and weighs 117 pounds. In comparison, the average American woman is approximately 5’4 and weights 140 pounds.

(Hammond, 2006)
PARENTAL INFLUENCES

• Parental influence is known to be one of the strongest predictors in the development of an eating disorder (Argas, 2010).

• It is common for children to fear disappointing their parents by being overweight. Girls are more likely than boys to receive negative comments from their parents regarding body image (Choate, 2013).

PARENTAL INFLUENCES CONTINUED

• Parents that engage in dieting or say negative comments about their own body could be giving their child the idea that being fat is unacceptable (Choate, 2013).

• Studies have indicated that girls as young as 5 years old are more likely to have concerns regarding weight if she grew up in a household with a mother who was also concerned about weight (Agras, 2010).
PEER INFLUENCE

- Girls will often engage in conversations with friends about body weight. “Fat talk” happens all the time in locker rooms, schoolyards, or even at work parties with older adults.

- A woman engages in fat talk when she complains about the size of her butt or her legs compared to another girl. This is a way for women to call attention to her imperfections before anyone else does.

(Nichter, 2000)

SOCIO-CULTURAL CONCLUDED

- Parents, peers, and the media have a powerful influence on a child’s perception regarding body image.

- It is important to teach children that beauty comes from within.

- Eating disorders are often caused by low self esteem, pressure to fit into one’s environment, and the fear of disappointing others.
DEFINING ATTACHMENT

- Attachment theory originated from the work of John Bowlby.
- He defines attachment as an affectional bond between a child and his/her primary caregiver.

(Bowlby, 1979)
DEFINING ATTACHMENT CONT.

- Attachment is an essential element of survival.

- It provides us with the necessary protection, comfort, and security to explore the world.

- Children need a stronger, wiser caregiver to provide them with the necessary guidance and care.

(Gleiser, & Schwartz, 2009)

AFFECT ON RELATIONSHIPS

- It is known that peoples’ earliest relationships have a profound effect on the ability to feel loved and accepted by others (Gleiser, & Schwartz 2009).
SECURE ATTACHMENT

- Children who grow up with a secure attachment describe receiving consistent care from their parents.

- Caregivers will often provide assistance on helping the child regulate intense negative affects such as fear, sadness, and anger.

(Gleiser, & Schwartz, 2009)

SECURE ATTACHMENT CONT.

- Securely attached individuals are also more likely to have open, honest, and equal relationships.

- In fact, these children usually have a strong sense of self and their relationships with other people.

(Gleiser, & Schwartz, 2009)
INSECURE ATTACHMENT

- Children with an insecure attachment towards their primary caregiver are known to have an internal capability to suppress emotions.

- Most likely the parent rejected or dismissed their emotions and therefore did not perceive the primary caregiver as dependable source of comfort and protection.

(Gleiser, & Schwartz, 2009)

INSECURE ATTACHMENT CONT.

- Children with an insecure attachment often times feel abandoned, overwhelmed, and alone.

- Children with insecure attachment describe having a longing to fulfill their inner emptiness.

- Numerous studies have found that insecurely attached children are more likely to encounter developmental problems such as the inability to develop autonomy and a positive self image.

(Gleiser, & Schwartz, 2009)
ATTACHMENT AND EATING DISORDERS

• Hilda Bruch was one of the first to suggest that a child’s attachment towards their caregiver plays a central role in the development of Anorexia Nervosa.

• She believed that eating disorders are traced back to ruptures between the parent-child attachment.

(Galperin, Gleiser, & Schwartz, 2009)

ATTACHMENT AND EATING DISORDERS CONT.

• Children that aren’t provided with a means of warmth and security are more likely to develop an eating disorder as a way of coping with life’s unpredictability and everyday stressors.

• Anorexic children are usually “hungry” for the parent’s affection, while at the same time feel hyper-anxious about being rejected.

(Galperin, Gleiser, & Schwartz, 2009)
THE NARCISSISTIC MOTHER

• It is commonly believed that children suffering from Anorexia grew up with a self-centered or narcissistic mother that is unable to recognize her child’s emotional needs.

(Aronson, 1993)

THE NARCISSISTIC MOTHER CONTINUED

• This parent would often times dismiss or neglect the child in order to cope with their own insecurities.

• Narcissistic mothers are often described as controlling, intrusive, and overprotective of her children.

(Aronson, 1993)
THE NARCISSISTIC MOTHER CONTINUED

• Children who grew up with a narcissistic mother developed the idea that they must be perfect and could not reveal any mistakes.

• A child's means of self-worth was determined by their ability to please the mother.

(Brown 2008)

INSECURE ATTACHMENT WITH THE FATHER

• Women with an insecure attachment towards her father can often times lead to a psychosomatic disorders such as Anorexia.

• It is common for women to repress the hurt and anger that she feels towards her father.

(Lenoard, 1982)
INSECURE ATTACHMENT WITH THE FATHER CONT.

Eating disorders are used as a survival technique or strategy to cope with the parent’s inability to identify or articulated the child’s emotional state.

(Leonard, 1982)

ATTACHMENT CONCLUDED

• Children unconsciously turn to food as a way to avoid anxiety or painful feelings towards their mother or father.

• Unfortunately, this means of survival does not fix the child’s problem, but acts as if a Band-Aid or quick fixes for sever issues.

(Galperin, Gleiser, & Schwartz, 2009)
OBJECT RELATIONS THEORY

The term object is commonly referred to as a person; which is usually the infant’s primary caregiver (Ainsworth, 1969).

Theorists use the term relations to describe the bond between the infant and their caregiver (Ainsworth, 1969).

Object relations theory stems from the psychoanalytic perspective that emphasizes an infant’s need for contact and connection with others (Ainsworth, 1969).
Perception of the Object

The child’s perception of the object is determined by three factors:

1. The quality of the relationship to their caregiver.

2. The child’s innate temperament

3. The way in which the child experiences and understands their world.

(Johnson, 1991)

Perception of the Self

- Object relations theorists are interested in the quality of these interpersonal relationships and how it forms a person’s inner images of their self.

- Children essentially want and need to develop meaningful relationships with others in order to feel a sense of belonging and positive self esteem.

(Johnson, 1991)
OBJECT RELATIONS AND MENTAL ILLNESS

- Theorists believe that “mental disturbances” are actually a result of disturbances in interpersonal relationships with others.

- The patient does not necessarily suffer from “symptoms,” but from “contact disturbances.”

- Many theorists shift their focus away from a patient’s mental illness and centers the attention on the individual’s inability to sustain fulfilling relationships

  (Johnson, 1991)

EMPATHIC FAILURES

- Theorists suggest that patients with Anorexia did not have parents that were attuned to his/her emotions.

- In fact, as a child they learned the caregiver would not be able to provide a means of emotional support when their life was messy and out of control. As a result there was a missing bond between children and their parent.

  (Sands, 2003)
MISSING BOND

- Object relations theorists view eating disorders as a way of filling in the missing bond between the parent and child.

- As stated before the caregiver does not provide the child with the warmth and support they need to soothe one’s self from distress.

(Sands, 2003)

FEAR OF DEPENDENCY

- The Anorexic patient fears dependency. This individual would rather use their body as a means to seek self-regulation than to be disappointed by the caregiver’s failure to be empathic towards their needs.

- Patients with Anorexia are just as afraid of being dependent upon others just as they are with food. Unconsciously the individual believes that they are strong, admirable, and self-sufficient.

(Sands, 2003)
SUBSTITUTING THE PARENT FOR FOOD

- Food is described as a “love-affair” for the Anorexic individual.
- Food acts as a substitute for the self-object or also known her primary caregiver.
- Anorexics may have internal thoughts such as “I am fat” or “I don’t need food to survive” but they are really just denying the desire for affection from the caregiver.

(Sands, 2003)

USING FOOD AS A FORM OF PROTECTION

- The caregiver’s failure to attune to their emotional needs has leave this person feeling rejected, alone and abandoned.
- Theorists believe that Anorexia serves as a way of protecting the child from these painful emotions.

(Sands, 2003)
USING FOOD TO MASK EMOTIONS

- The child is more inclined to hide their true self than turn towards others for emotional affection.

- Self-starvation is just an act of rebellion, anger, and rage towards the parent(s).

(Johnson, 1991)

THE FEAR OF FOOD

- In the past this person has experiences intimate relationships with others as traumatic.

- Over time the anorexic patient fears food just the same as they would fear connection to others.

(Johnson, 1991)
SUMMARY

• Usually the onset of Anorexia isn’t directed at a single cause, but a combination that is intertwined with one another.

• Hopefully this workshop gave therapists a deeper understanding that Anorexia Nervosa is a complex disorder.

• It is important for therapists to consider the multi-contextual aspects when working with clients in therapy.

QUESTIONS?
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