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| **Psychological explanations for anorexia nervosa** | | | |
| **Family systems theory AO1** | | | |
| Minuchin et al. (1978) identified four main features of what they called a typical anorexia family. Because anorexia nervosa overwhelmingly affects females more than males, family systems theory focuses on the relationship between daughter and mother when being used to explain AN.   1. **Enmeshment**   Members of anorexic families are overly involved with each other. This comes about because boundaries within the family are ‘fuzzy’, the result of poorly defined roles and a lack of leadership. Family members spend a lot of time together, to the exclusion of others; they constantly impinge upon each other’s privacy; they speak to each other on the assumption that they know what each other is thinking and what their views are. Families become **enmeshed** because the self-identities of each member are all tied up with one another. An adolescent daughter in an anorexic family faces the challenge of asserting her independence and differentiating her identity from everyone else’s, especially, her mothers. But the enmeshed family is structured in a way that prevents this, so one way for the adolescent to assert her independence is by refusing to eat.   1. **Overprotectiveness**   Family members are constantly involved in protecting each other from external threats. They nurture each other obsessively, in a way that reinforces family loyalty and leaves no room for independence. Mara Palazzoli (1974) described how the mother of a daughter with AN in an enmeshed family consistently understood her role as a personal sacrifice. That is, all the decisions she made she felt were for the benefit of her daughter and not for herself. This may sound admirable, but of course it makes it much easier to blame the anorexic daughter when things go wrong.   1. **Rigidity**   Interactions within the anorexic family are extremely inflexible. Members deny the need for change and work hard to maintain things as they are. In most situations rigidity is not dysfunctional because the family ‘coasts’ along as it always has dine. But problems arise when circumstances change, due to some internal pressure or external threat. The family is too rigid to adapt and is thrown into a crisis. For example, an adolescent daughter seeking greater independence cannot be accommodated. The rest of the family – particularly the mother – moves to quash this attempt at self – differentiation, giving the daughter no room to manoeuvre. The predictable outcome is dysfunctional behaviour of some kind, often an eating disorder.   1. **Conflict avoidance**   The foremost priority of the anorexic family is to avoid conflict, and members will take whatever steps are necessary to prevent it or suppress it if it occurs. For instance, there can be no discussion of any issues where a difference of opinion might arise. As these issues are often problems of one kind or another, this means that they are not resolved and continue to refuse to eat, and starves herself, as the family refuses to accept there is anything to discuss.    **Autonomy and control**  Minuchin et al. argued that families exhibiting the features outlined above (i.e that are over involved, over-protective, inflexible) are actively preventing its members exercising autonomy and control. This argument was extended by the psychoanalyst Hilde Bruch (1978). She suggested that anorexia is caused by the adolescent daughters struggle to achieve the autonomy and control she craves. Although the father is involved in the dysfunctional family dynamic, it is the mother in particular who is domineering, intrusive, discourages separation and does not accept her daughters need for independence. One outcome of this confusion in the daughter, which expresses itself in three major symptoms of AN: a distorted body image, an inability to identify internal body states such as hunger, and an overwhelming feeling of a loss of control. The self-starvation which is central to anorexia is, according to Bruch, a desperate attempt by the daughter to control her self-identity as someone independent of the family. She controls her destiny by controlling her body, and weight loss is the visible ,measure of her success – the thinner she gets, the greater her degree of control. She also gains autonomy, by disrupting her independent relationship with her mother. | | | |
| **Family systems theory AO3** | | | |
| **Supportive research**  P: A strength of the family systems theory is that it has supportive evidence. Particularly for autonomy.  E: Brockmeyer et al. (2013) studied 112 female AN patients and healthy control participants. They found that the AN patients showed significantly greater desire to be autonomous.  E: This corresponds with the results of an earlier study by Strauss and Ryan (1987) which found that female AN patients demonstrated greater disturbances of autonomy. They had a more controlling style of regulating their own behaviour; they differentiated less clearly between themselves and other family members; and they perceived poorer communication within their families.  L: These findings support FST because they show that the desire for autonomy – especially when it is prevented – may be a risk factor specifically for AN in daughters | **Inconsistent evidence**  P: However, a weakness for FST is that other evidence has been inconsistent as the theory may be vague.  E: For example, Aragona et al.(2011) studied the families of 30 female Portuguese patients being treated for eating disorders and found that they were no more enmeshed or rigid than a sample of non-eating disordered families. The researchers suggest that this failure to confirm FST may be because they used a different method of measuring enmeshment and rigidity than other studies (a self-report questionnaire as opposed to observer or interviewer ratings).  E: The fact that research studies find different outcomes depending on methodological variations illustrates a wider problem with a psychodynamic explanation of AN: the difficulty in confirming predictions derived from vaguely defined concepts such s enmeshment, autonomy, overprotection, and so on.  L: This is a major limitation of FST, because it means that research has failed to reliably identify the ‘typical anorexic family’. | **Treatment applications**  P: A strength is that there is evidence that the therapies based on FST have had some success in treating AN.  E: For example, behavioural family systems therapy (BFST) attempts to disentangle family relationships, encourage the AN sufferer to interact more with people outside the family circle, and reduce parental control over eating. Arthur Robin et al. (1995) tested the effectiveness of this therapy on a small sample of 11 female AN patients. The treatment lasted 16 months, at the end of which six patients were considered to have recovered. A further three were found to have recovered after a one year follow up period. This compared favourably with the outcome of individual therapy.  E: This is a strength of this theory because it shows that it has had benefits in helping patients recover.  L: As a result the credibility of the theory is increased. | **MAID** |