Anorexia Nervosa

by Bob Smith, M.D.

[Abstract: Dr. Bob Smith thoroughly explores and reports the latest information on the condition known as Anorexia Nervosa, and concludes that while medical attention may be necessary in life threatening circumstances, at base the condition is non-medical and requires biblical counseling which he finds adequate to meet it.]

Anorexia means "without appetite" and nervosa means "nervous". Thus, the name of this problem means "nervous loss of appetite". This is "actually a misnomer for this disease. These patients have in no way lost their appetites. Rather, they have a morbid fear of gaining weight."[1]

"Drastic and often debilitating weight loss is the primary physical manifestation of anorexia nervosa. The typical patient is a teenage girl, although symptoms may appear from preadolescence into the 20s and 30s."[1] "The peak age of onset is between 10 to 15 years."[2] This condition is found in males about 5 to 10% of the time. "The anorectic's overriding concern in life is staying as thin as possible."[3] She distorts the definition of obesity so severely that a very emaciated person will consider herself fat, overweight or obese. "She may be 20% to 30% under expected weight and be strikingly emaciated, yet insist she looks fine and isn't even sick. Indeed, she usually wants to lose more weight because she continues to see herself as fat."[4] Since she doesn't consider her definition and condition abnormal, her perception is very unresponsive to reason or objective demonstration.

"Even though they may suffer from hunger pangs, they will not admit it, but may revel in their ability to ignore the discomfort. Some girls actually convince themselves that they enjoy it. Most anorectics feel an overwhelming need to be perfect and they equate thinness with perfection."[5]Though she may be as much as 20 to 25% below her normal weight, with her distorted view of her body she sees herself "as nothing less than pleasingly slender."[6] She refuses to see how emaciated she has become but receives "increasing satisfaction with each pound lost. She lives in fear of ever becoming 'fat' — which, in some cases, means maintaining a weight below the level compatible with resisting disease"[7] and dealing with life. Even with 30% of the weight lost some still consider themselves overweight.

The eating habits are consistent with this attitude. She "may be frantically preoccupied with caloric content of food, often focusing on leafy vegetables and carrots as the sole source of food supply."[8] "Bizarre behaviour regarding food and eating habits are universal. These patients have detailed knowledge of and excellent memories for the composition and caloric values of foods. They deliberately compose a diet that is low in calories and high in roughage. They tend to eat minute portions of an unvaried and exceedingly limited selection of

foods, sharply restricting fluids as well. They often refuse to eat with the family or where they will be observed. There is surreptitious discarding of food. Hunger is steadfastly denied, although this denial is belied by a preoccupation with marketing for food, collecting recipes, preparing food for others, and feeding younger children."[9] "Oddly enough, despite her eccentric eating habits, the typical anorectic maintains a tremendous interest in food, taking an inordinately long time to consume a tiny meal that was hours in preparing. Some patients insist on taking over the family cooking, spending much time in the kitchen, and taking great pains to prepare elaborate meals. They claim they feel full just watching others eat."[10] Sometimes the anorectic will dream of food. Her rituals over food and eating help her believe that she is in control of her body. "Anorectics typically restrict calories in the form of fat and carbohydrates but allow themselves some proteins and vegetables and lowfat cheeses."[11] "The cardinal feature of anorexia nervosa is a willful and covertly triumphant pursuit of thinness that often leads to life-threatening weight loss."[12] She is either unaware of hunger or is at least ignoring it.

"A pattern of enforced hyperactivity is very characteristic and they seem able to sustain a level of activity that would be a challenge to a normally-nourished adolescent. They go to all sorts of exertional extremes, avoiding elevators and conveyances, while adhering to demanding exercise, athletic or dancing regimens."[13] "Cachectic[14] as she is, a typical anorectic pushes herself to increased motor activity in an attempt to burn up the few calories she has consumed. Her activity is more agitation than exercise and far exceeds that of the normal physical fitness devotee. She may jog, swim laps, or do calisthenics to the limit of — or even beyond — her endurance without admitting fatigue. Some parents report that their daughter repeatedly runs up and down stairs in a compulsive, non-productive manner. Recovered patients occasionally admit that they suffered exhaustion and great pain during these ordeals. . . ."[15]

"Their behavior with adults is demanding and manipulative. They tend to be withdrawn, angry, jealous, and unhappy."[16] They avoid school and are very feeling oriented and changeable.

Anorexia may produce some very obvious changes in the body. First of all, weight loss is the most obvious sign. People who have continued this for a period of time may appear to be just 'skin and bones.' "Facial contours may be preserved after weight loss is well under way, owing to the persistence of facial fat pads. Thus, parents, who may not have occasion to see their adolescent daughter undressed, are often unaware of the amount of weight loss."[17] Her skin is often yellowish colored, rough, and scaly. There may be a growth of long fine hair on the body but especially on the back and buttocks. The hair of the scalp is often dry and sparse. She may develop a low temperature, a pulse that is slower than 60 beats per minute, slow breathing and a blood pressure that may drop to as low as 70 millimeters of mercury. These things will return to normal when the weight returns to normal. In addition she complains of constipation which may at times be accompanied by pain in the abdomen. Many have difficulty tolerating cold and the degree of intolerance is roughly proportional to the

degree of weight loss. One of the first physical changes that occurs as a result of the starvation is cessation of the menstrual cycles. "For causes not yet understood, about half of these patients stopped menstruating before significant weight loss had occurred, and many fail to resume menses after attaining normal weight."[18] Hormone imbalance, changes in the electrocardiography, and certain body chemistries may also occur. "Up to 15 per cent mortality has been reported among these patients, with deaths caused by starvation,"[19] complications of starvation, or complications of treatment.

"At the other extreme, some anorectics crave food and go on wild eating binges. Such a patient may consume incredibly huge quantities of anything from junk food to elaborate restaurant meals; immediately afterward, remorseful and disgusted by her loss of control, she forces herself to vomit. Constantly hungry, she is driven to repeat this routine several times daily. Once this pattern is set, it is very difficult to stop. Some patients, in an effort to reduce weight even further, habitually will take laxatives, diuretics, and enemas."[20] This condition is called bulimia, bulimia nervosa, or bulimarexia, which "literally means 'ox hunger' or a voracious appetite, but in recent years it has come more and more into use for binge-eating."[21] "Most patients in fact overeat with the forethought that they can resort to vomiting. Thus, the whole sequence generally includes eating binges of sometimes stupendous proportions followed by self-induced vomiting which re-establishes the status quo."[22] Vomiting is a purposeful manipulation of body functions to help accelerate weight loss. The person does not overeat only to ease hunger feelings but also to deal with other uncomfortable feelings such as depression, guilt, and anxiety which are closely interrelated with their problems. "Patients discover that consumption of carbohydrates, in sweets or ice cream, and the activities associated with the eating process, such as biting, chewing, and swallowing, have an emotionally soothing effect and seize on this mechanism for relief of distressing thoughts and emotions. Then, not only hunger but other feeling states such as frustration, tension, emptiness, and boredom induce a craving for food. Normal eating is not sufficient to dispel this tension, but binge-eating does, even though it is accompanied by a constant fear of not being able to stop eating. It is worth mentioning that a similar perpetual fear of not being able to stop eating is just as often present in fasting patients who have never submitted to their impulses."[23] The bulimic individual may become involved with alcohol and drugs for the same reason as excessive eating. The eating habit may be so great that they become involved with stealing in order to support the food habit. Although these people "do not become dangerously thin,"[24] the laxatives, diuretics, and enemas may produce dehydration, chemical imbalance, and cathartic poisonings.

"Anorexia nervosa and bulimarexia appear to be syndromes that exist on a continuum. At one extreme are those anorexics who avoid food altogether. At the other extreme are the bulimarexics who, while bingeing and vomiting, keep their weight within normal limits. In between are many patients who have features of both anorexia and bulimia nervosa in varying degrees of severity. Sometimes patients with anorexia nervosa subsequently become bulimarexics,

especially if they have been inadequately treated, and bulimarexic patients may transiently develop anorexia nervosa."[25]

Some contrasts between these two conditions are important. "Whereas the anorexic is more successful in appearing disciplined, the bulimarexic patient is overly chaotic."[26] "Although bulimic patients regularly yield to the incorporate wish to gorge, anorectics try desperately, usually unsuccessfully, to deny this wish altogether. A careful history of anorexic patients will often reveal weight gain, or even bingeing for brief periods, prior to their voluntary starvation. The bulimic and anorexic are tantalized by the thought of food, which soothes, reduces tension, and fills an inner void. Food may also represent something toxic or an intrusion which can overtake and control. But the ultimate conscious fear of patients with eating disorders is loss of control and of becoming fat."[27]

"The food-related symptoms in patients with eating disorders are a sign of a more generalized disturbance in mental functioning and social adjustment, often of long standing. While social pressure, fads and cultural emphasis on slimness can channel people into unusual eating habits, underlying" attitudes "and family disturbances are necessary preconditions for such sustained abnormal behaviour."[28]

"Common to all patients with anorexia nervosa is the misperception of their body image, their apprehension that they are fat when, in fact, they are cachectic.[14] This misperception is totally unamendable to reason or objective demonstration. They view eating and all physical indulgence as evidence of personal weakness. To resist food, even under extreme outside pressure of internal hunger, is to demonstrate that they have complete control."[29]

Other causes for extreme weight loss must be considered. These are diabetes, diseases that prevent absorption of food from the bowels, certain inflammatory diseases, hormone dysfunction and cancer. "A diagnosis of anorexia nervosa is indicated when a young woman presents a clinical picture that includes substantial weight loss, amenorrhea,[30] and a preoccupation with food and weight — a pursuit of slimness, and a fear of weight gain or of losing control of eating. You can forget the medical tests if they have those signs."[31]

How does all this get started in these people? Some of this problem grows out of the "continuing cultural emphasis on slimness, not only as a condition for attractiveness and acceptability, but also for social class — it's very hard to be a fat upper-middle-class person. There are many more cruel remarks addressed to girls about that than about disfigurement. In a population at Radcliffe or a girls' prep school, the percentage of anorexics is going to be tremendously higher than among some inner-city, more impulse-oriented group."[32] "As a culture, we admire thinness too much. In order to be more popular in school, young girls may try to lose weight and may develop anorexia nervosa. Even when they are very much underweight, these girls still believe they're fat."[33]

Conflicts, fears and guilt about sexual development, activity and potential of pregnancy are present in many of these people. For some who wish to avoid sexuality, "the bulimarexic may have the impulse to 'pig out', make herself fat, and thereby no longer threaten or feel threatened by others. But because of her stan-

dards of perfection, she cannot accept feeling fat and will regurgitate and diet to become 'svelte' — until the anxiety again mounts and the vicious cycle repeats itself."[34] Some "admit that they fear sexual maturity and hope to avoid it by maintaining a flat, boyish figure."[35]

"Patients with eating disorders typically come from families with weight pathology, including obesity, preoccupation with dieting and slimness, and emphasis on physical beauty as a sign of perfection. During adolescence, mothers of anorexic girls frequently had eating problems similar to their daughters'."[36]

We are told, "The parents are usually industrious, conscientious, striving people with high standards of accomplishment. They place strong emphasis on appearances, decorum, and visible evidence of achievement. There is an emphasis on material and cultural nurturance with great pressure for success in school."[37] The mothers are attractive and have gained some skills, are self-centered and often depressed. The fathers tend to be aloof, passive and have difficulty dealing with life. The marriage relationship is characterized by coldness and much disagreement on basic issues. Problems with alcohol and depression are often found in these families.

"Most patients are middle- or upper-class girls in early puberty, previously compliant, apparently well adjusted, usually pretty, likable, and possibly a little chubby, who spontaneously begin to 'diet' in order to improve their appearance. The onset is relatively abrupt and is often preceded by a critical life event, such as moving to a new neighborhood, changing schools, losing a close friend, taking a trip, or onset of menses."[37]

"Certain patterns emerge in case after case — an apparently happy, close-knit, success-oriented, middle- or upper-class family, and a patient described by her parents as a well-behaved, obedient child who excels at school and who has fulfilled their highest expectations. They tell you that she was an absolutely perfect child — until she began to starve herself. You will find it difficult to determine just when anorexia began in a given patient. Ask the parents about any changes in the child's habits. Sometimes they may recall the sudden appearance, a few years before weight loss, of 'driveness' characterized by fanatic dedication to school work, studying far into the night, and satisfaction with nothing less than perfect marks. They might also remember an earlier increase in physical activity that seemed insignificant at that time."[38] This girl has been a perfect child "only by conforming to her parents' ideals, participating passively in life, and constantly striving to fit in and do the expected."[39] Even though she is passive there is an inner resentment about being unable to do what she wants to do and in the process there is also an attempt to gain parental approval of her actions. This becomes so strong that she develops a 'perfectionistic' attitude as a result. "At some point, such a child strives to attain a modicum of control over her own life. Usually, her first attempt at weight loss is precipitated by a commonplace event: a parent's casual suggestion that the patient lose a few pounds for the girl's entrance into a new school where she strives to be popular. She may find that the weight comes off easily and is delighted

with the results. She soon realizes that she has discovered a method by which she can at last exercise control over her body — and ultimately over her family. Perhaps for the first time in her life, the anorectic has a feeling of power."[40] "Initially the patient may actually receive reinforcement in her weight loss effort from the praise and admiration of her friends. Unfortunately, what may have begun as an attempt to be more attractive in the eyes of peers eventually results in a self-imposed isolation as weight loss proceeds. This does not lead to improvement in social status. Instead, the isolation promotes further self-degradation and may intensify weight loss."[40]

"An outstanding almost unbelievable feature is the ability to manipulate her family and environment through her aberrant eating behaviour. Basically she controls her world through the use of the self-destructive mechanism of starvation."[40]

In general, starvation is an extreme, incorrect and unbiblical attempt to deal with various problems in life and is actually suicidal if it is not stopped. As in all problems much detailed data need to be gathered at the beginning. Look for problems in the following areas, including those already mentioned:

1. Lack of salvation.
2. Unbiblical husband-wife relationship in parents.
3. Unbiblical parent-child relationship.
   a. Reacting to parental failure—bitterness.
   b. Over-critical parents.
   c. Over-protective parents.
   d. Parents that avoid or ignore problems.
   e. Problems with leaving according to Genesis 2:24, etc.
4. Unbiblical view of self.
5. Unbiblical view of authority.
6. Manipulation.
7. Blameshifting.
8. Not accepting various aspects of adult responsibility.
9. Unbiblical view of sex.
10. Failure to deal with anger, worry, fear, or guilt biblically.
11. Boredom with life.
12. Holding a grudge against someone who has committed an offense.
13. Recent death, illness, separation in the family, or move by the family.

Anorexia is essentially an unbiblical response to one or more of these problems. For each difficulty the biblical response or solution must be shown and adopted as a way of life by the counselee for success to occur.

The most obvious violations of biblical principles are the following:

1. Accepting wrong standards for health (what is good for the body).
2. Abuse of the body (which may have become habitual). There is disrespect for the body, which is treated not as a gift from God but as the person's possession to be used as she desires.

3. Failure to listen to reason and counsel.
4. Failure to change.
5. Rebellion against God's Word.

These are the results of unsolved problems in other areas. In dealing with this problem adequate data must be gathered and biblical solutions found and presented. As we move on to talking about dealing with the weight loss itself, correction of the physical problem will not occur unless underlying conflicts have been solved biblically. Every standard the patient uses must be challenged and measured by God's Word. The family relationships need to be carefully investigated in detail. The person who claims to need control of her body for a sense of competence must realize that God's Word is the only place to learn the right kinds of control needed in our lives. Those who claim to have irresistible urges to eat need to be taught that God's Word teaches this is a habit and not a physical problem. It is a learned behavior and it can be unlearned. They have not lost control of themselves but they have learned unbiblical ways of dealing with problems. They have allowed these ways to become habits and also have allowed these wrong habits to become deeply ingrained and therefore believe they are uncontrollable. Most anorectics use what they believe others think about weight as a guideline for evaluating themselves. Use of nouthetic principles to find and deal with the various problems is necessary.

"Management of anorexia nervosa is another area in which considerable controversy still exists."[41] "Treatment is both difficult and controversial."[42] Contemporary secular treatment has ranged from psychotherapy to behavior modification with various mixtures of the two and family counseling added. No matter which method has been used, there is very little difference in the immediate and long-range outcome. In reviewing the literature, whether any of these methods "can significantly alter the course of the illness"[43] is frequently doubted. Since the secular methods of treating this condition are so many and varied, contain non-medical aspects, and offer no real hope, the biblical counselor should not be intimidated by those who disagree with an aggressive use of God's Word. Science does not understand what causes the problem nor does it have a clear, firm method to handle the condition. There are numerous statements in the literature that claim the problem has a so-called psychological basis. "Everyone's impression is that psychological factors play an important role in the development of the syndrome, but how the psychological risk factors interact with the physiological ones is unclear."[44] These 'factors' are actually unbiblical responses to problems in the person's life. These people do not need psychotherapy although their behavior does need to be changed. Sinful thoughts and actions must be replaced with biblical thoughts and actions. The major difficulty with all of the contemporary philosophies is that they are treating these people as though they have an illness which may or may not be reversible. The problems faced by the individual are presented as having no solutions or ways of responding to them. The person who overeats is described as having uncontrollable or irresistible urges. All of these statements remove

personal responsibility. Biblical counselors know that this does not conform with God's Word and His method of dealing with problems. The counselee must be given God's hope and help for the problems her lifestyle is avoiding.

While counseling focuses upon the problems of life the counselee is facing, the physical aspect must be handled as well. To protect her health she must begin gaining weight. Many times the anorectic has been under much pressure to eat. Her problem may be "aggravated by the parents' concern and their constant nagging at mealtime."[45] The pressure may be applied by anger, scolding, harsh talk, pleading, begging, etc. Rebellious people tend to become more rebellious when placed under constant pressure to change. In their rebellion they want to get rid of the pressure or get out from under it. They may temporarily give in only to get the pressure off, not because it is right. Constant pressure to change must be replaced with a calm, relaxed attitude and atmosphere in which the counselee makes decisions about eating with appropriate reward and punishment for eating or not eating. This is best accomplished through gain or loss of significant privileges (see pages 103-125 in *Christian Living in The Home* by Dr. Adams). These must be established and clearly discussed prior to being instituted. A balance between reward and punishment is necessary. Since there has very likely been an over-emphasis or pressure to eat, it needs to be greatly reduced. If she eats she is to be rewarded and praised. If she doesn't eat she should receive the appropriate punishment without much comment. Any discussion should be limited to what she is doing to herself and her relationship to the Lord, not what her actions are doing to her parents.

Parents should not attempt to deal with other aspects of the problem until the counselor has given instructions. Mealtime should be a relaxed, pleasant time. There should be no nagging or coercion. However, parents must beware of the cunning and manipulation of the counselee. The counselee should be treated equally with other members of the family. Food should be passed or placed on the counselee's plate the same as for the rest of the adult members of the family. Adequate fluids and supplemental vitamins should be encouraged. When food is refused, no comment should be made until the meal is over. Give the counselee any opportunity to change her mind without pressure, giving her credit for knowing the consequences of her decision. Whatever she does during mealtimes is her choice, and the consequences are also her choice. The focus should be changed from her eating and her body to her as a person. As she enters into the family discussions, the family should listen to what she says. Listen for red flags (clues to problems) to be discussed with the counselor. Look for good qualities in her. Commend these as well as good points in her conversation. But don't limit this to her. Do it for each other as parents and for all the other children as well. Don't make the management of her problem conspicuous (other than areas that need changing for other members' benefit or as a consequence of her choices.) By parental action she must know that she is accepted as a person even though her eating is not acceptable. She must not be allowed to manipulate through failing to eat. A goal of 1 to 2 pounds per week should be set for her. To determine her normal or healthy weight use her weight during her early teens

when she was still in good health and unconcerned with diet and weight.

Her radical control of her eating can be used to encourage her. She is able to reduce eating to the point of harming herself. By using that same control, with a right view of her body and proper handling of problems, she can properly eat and hold her weight where it should be, without fear of becoming literally overweight or fat.

In dealing with bulimia structured eating is necessary. When the person has an urge to eat, she should call a friend, get busy and avoid eating alone. She should eat only at specified times and places, eat slowly and eat only what she needs. The principles in the pamphlet "What Do You Do When You Know That You're Hooked?" by Jay Adams are very useful to help her change her wrong eating habits. All of her wrong approaches to problems also need to be confronted and handled biblically.

Resistance is to be anticipated. "Regardless of the degree of cachexia[4], anorectics are extremely defensive and tend to resent any medical intervention. They may resort to deceptive and manipulative behaviour to counteract such nutritional management."[46] "Remember that these patients, debilitated as they are, are still very determined to sabotage any eating procedure."[47] If she resists the efforts, then hospitalization will be necessary, but only when her life is in danger.

Parental counseling is indirect through the atmosphere and attitude that they produce in the home. Dealing with their own personal failures that have contributed to the daughter's problems gives her hope and shows their genuine concern for her. This often opens the door for them to help her deal with specific problems. The counselor must vigorously pursue dealing with these parental failures. They do not excuse the counselee's sin but are factors for which parental responsibility must not be minimized. The counselee's parents are her best counselors, but until they have built involvement and a biblical relationship with her, she will ignore their attempts, especially if she sees more concern for themselves than for her in those attempts. There should be only one counselor until the parents are saying the same thing as the counselor.

How can one know when her life is in danger? If she is still active and not sleeping or laying around considerably, she may not be in serious trouble. Her physician, by examination and tests, is the only one to really help with this decision.

The medical management of weight gain is sometimes done in a hospital. Many times this is because the family is unwilling to take the pressure off the very thin, emaciated person they have in their home. They may be frightened for her health and may view removing pressure as harmful. They may be embarrassed because a member of their own family looks so bad. Other reasons may hinder their proper management of the individual at home. However, the family is actually the best help to reverse the process. Verbal pressure to force her to eat must be replaced with appropriate rewards for eating and punishments for failing to eat. If a person will not gain weight in a properly structured home life, then consultation with one's personal physician and hospitalization

may be needed. A difficulty arises here in that many physicians will want to call in psychiatrists and psychologists for further help in managing the problem. The person with anorexia needs to be warned (without nagging or pressure) that if she does not handle the problem in a biblical way, this may happen.

Even when hospitalized the home management conditions should be continued. The physician should instruct the hospital staff that anyone in contact with the patient must follow this procedure. Food trays are taken to the patient without comments about her eating. Detailed records of all she eats and drinks are kept, along with her daily weight. She should be praised when she eats the food served. Privileges are also given or lost depending on eating. Discussions with her center on things other than food (i.e., what she is doing, what she likes about it, other things she likes to do, school, social activities, etc.) In such conversations, conflict areas may surface. These should be reported to the physician and counselor. The bottom line of the reward and punishment system is that if the weight doesn't level off and start climbing, the counselee will have to be fed intravenously. This will be continued until she changes her actions, begins eating, and the weight begins to stabilize and increase.

The person who refuses to eat even after intravenous treatment (literally commiting suicide) must be approached as one rejecting truth. If she is a believer, church discipline will need to be applied. She must be confronted with her rebellion against the authority of God and rejection of His truth. She may claim to be a believer but her actions are not consistent with God's Word. If she doesn't repent and change, discipline is necessary. The goal is to restore her (not cut her off) but proper discipline may need to occur to produce repentance. If she is not a believer, she needs to accept Jesus Christ as her Saviour.

Even though the home or hospital atmosphere is calm and relaxed without criticism of failure, counseling is not stopped. It should be continuing throughout each step, as it is not separate from the medical problems. If there is a refusal to follow the structure to produce a weight gain, this means either the underlying problems have not been determined and handled biblically or the counselee is resisting obedience to God's Word.

In the hospital there should still be only the original counselor. Counseling done by the hospital staff must be limited to the environmental structure they produce. As the counselor allows changes, these may be made. If the physician will not cooperate in this, seek one who will. If one is not available, the counselee may need to be hospitalized anyway. Find out how she will be treated by the physician and staff. Tell her they will attempt to treat her problem without using the Bible. Express sorrow that she is choosing the counsel of the world rather than God's wisdom. Explain that going to the hospital in these conditions is turning away from hope which is only found in God's Word. Leave the door open to working with her when and if she comes out of the hospital. Don't forget to use repeatedly Proverbs 15:13. If she refuses to use the biblical principles, the physician and hospital staff may want to apply medications and other therapy, which again is turning away from biblical principles. If she has refused to deal with problems biblically and her life is at stake this may need to be allow-

ed. But she must understand it is the counsel of the ungodly, it is temporary and is only applying a band-aid where major surgery is needed.

In summary, anorexia nervosa (or bulimia) is an unbiblical response to various problems in a young lady's life. She uses her body in this response. Her hope is thorough control of physical desires for wrong reasons and to harmful degrees. She sees no hope in dealing with her various underlying problems and so avoids them. She must be given hope through God's Word and called to biblical obedience. Her resistance to change must be met with loving, firm and aggressive rewards and punishments. In addition to spending time with the girl, considerable time must be spent with her parents learning and dealing with those factors that have contributed to her problem. As in all problems, confession of sin and biblical replacement of sinful habits are necessary to reach victory. Pleasing God is far more beneficial and satisfying than pleasing self: Proverbs 15:13; Matthew 11:28-30.

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15. Frazier, page 149.
16. Millman, page 73.
17. *Ibid*., page 72.
18. Frazier, P. 145. (Counselors should inquire about this symptom where the problem is suspected lEd].)
19. *Ibid*., page 150.
20. *Ibid*., pages 148, 149.
21. Casper, page 1030.
22. *Ibid*., page 1035.

23. *Ibid*., page 1034.
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