

Chapter 14

Family Structure of Interpersonal Relationships in the Eating Disorders

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Much of the early and current literature on bulimia and related eating disorders implicitly assumed or openly postulated a linear model of development and treatment. The linear model includes all the therapeutic methodologies that focus on the individual patient. Traditionally, these approaches attended to the medical-neurological, psychodynamic, and behavioral aspects of the disorder.

Minuchin et al [1] discuss the differences between the linear and systems model; they state that:

the system model posits a circular movement of parts that affect each other. The system can be activated at any number of points and feedback mechanisms are operative at many points. The activation and regulation of the system can be done by system members or by forces outside the system. In the linear model, the behavior of the individual is seen as sparked by others. It presumes an action and a reaction, a stimulus and a response, or a cause and effect. In the systems paradigm, every part of a system is seen as organizing and being organized by other parts. An individual's behavior is both caused and causative. A beginning or an end are defined only by arbitrary framing and punctuating. The action of one part is simultaneously the interrelationship of other parts of the system.

Sluzki [2] discusses how the emphasis on systems-oriented approaches reflects its main concern with patterns of symptom maintenance in contrast to the process of symptom production. Sluzki states:

The hypothesis about the patterns of symptom maintenance is drawn through observing and probing the interactional context of the symptoms in the present. This view is based on the premise that, regardless of their ultimate origin, symptoms or conflicts of any sort can only persist if they are maintained by ongoing interactional patterns. (p. 275)

An important issue is the emphasis on familial interactions and styles. Sluzki adds:

The guiding question is how the interpersonal matrix composed of the behaviors of all the participants, supports the symptom rather than what caused the symptom to appear. The why in a symptom is therefore by-passed, in favor of the explanation of how, that is, of those behaviors of each and all the participants that contribute at present to the persistence of maintenance of the symptomatic behavior. (p. 274)

Sluzki elaborates on how his position departs radically from traditional psychiatric thinking. He discusses

how the systemic paradigm will take focus away from the process of symptom production (ie, why did the symptom occur?) to the patterns of symptom maintenance (how is the symptom maintained?). He states:

That persisting symptoms and patterns may lose ties with the collective conflict that triggered or anchored them in their origin. It could even be proposed, within this paradigm, that many collectively maintained symptoms do not have a discernible triggering conflict at all, and that their existence is the result of random phenomena that became anchored progressively by all the participants of the collective, as the symptoms-maintaining patterns became organizing principles for the group: they insure family rituals routines, they introduce order, they become cherished markers of collective identity. (p. 275)

Sluzki [2] states that the systemic paradigm requires a shift in epistemology that gave birth to the field of family therapy.

Clinicians and researchers have been trying to distinguish different subtypes of anorexic patients. The focus of study has been dividing those anorexics who continuously restrict their food intake in contrast with those who have clear-cut episodes of self-induced vomiting to prevent digestion of food. This latter description is associated with bulimia [3-7]. There has also been a population of patients identified who have bulimia but maintain a relatively normal weight [7-12]. There is little systematic research in comparing these subtypes with one another. This chapter will focus on current theories and empirical research regarding familial interactions and relationships as well as general systemic factors on the maintenance of eating disorders. More specifically, this chapter will review the current knowledge regarding the family structure of interpersonal relations and how familial patterns manifest themselves in the anorexic subtypes.

ANOREXIC FAMILY SYSTEMS

Family therapists have approached the problem of anorexia nervosa as reflecting a specific type of family interactive style [1,13-19]. On the surface, anorexic families appear to have a perfect, ideal environment that reflects a calm, orderly demeanor between family members. However, when anorexic families are more closely observed, their interactions appear superficial and empty. There is seldom any expression of affection or warmth [19]. When feelings are expressed, they are usually overintellectualized [18,20]. Family members

do not take a specific stand on an issue, and therefore, it is easy to get confused as to who is expressing a position [21]. Anorexic families have a low tolerance for watching others in the family suffer. As a consequence, offspring are extremely sheltered [18]. Parental dyads appear secure, although there may be underlying dissatisfactions and tensions; these feelings are usually submerged and not discussed [17-20]. Bruch [20] suggests that the parents of anorexics appear to have loveless marriages. There is a tendency for the parents to put high expectations on their anorexic offspring to overcompensate for their own frustrations in one another. There are also descriptions of how the anorexic unites her parents by remaining ill [22].

Yager [23], in a review article on family issues and anorexia, describes how anecdotal reports of parental personality styles as well as parent-child interactions show a great amount of variability. Mothers' relationships with daughters are reported by some to be overinvolved, by others to be ambivalent, and by still others to be rejecting. Yager cites studies where there are reports of "normal" relationships between parents and their children. Despite these contradictory observations noted between mother-child interactions, some general consistent themes do emerge. Anorexic mothers tend to foster ambitions for high achievement in their daughters. Mothers are said to overly invest themselves in their daughters because of feelings of frustration in their own career goals. Mothers of anorexics are involved socially, but they have a lack of intimate friends. Many times, the anorexic daughter is mother's confidant [20]. Because of underlying dissension in the marital dyad, mothers turn to their daughters to fulfill their empty lives [24]. The overinvolvement between mothers and anorexic daughters reflects difficulty with mothers separating from their own mothers [19,24]. With the overinvolvement between mother and anorexic daughter, there are also reports of lack of warmth and understanding in this relationship [19,25].

There are also wide variations in father-daughter dyads. Some descriptions of anorexic fathers depict them as kind and affectionate, while others report passive, ineffectual, and weak behaviors; in addition, they are peripheral to the family [26,27]. There are descriptions of father and daughter coalitions, however; it should be noted that these patterns have been described more in anorexic bulimic (patients who are currently showing a combination of anorexic and bulimic symptoms or have a history of one symptom while currently manifesting the other) and normal-weight bulimic families (Schwartz RC, Psychologist, Family Systems Program, Chicago Institute for Juvenile Research and Department of Psychiatry, University of Illinois, College of

Medicine, Chicago, Illinois, personal communication, 1982).

Taipale et al [24] report alcoholism and infantile behavior in fathers of anorexics and bulimics. Twenty-five percent of the fathers of 120 anorexics showed signs of depression at the beginning and near the end of treatment. The anorexic's father's depression being more visible at the end of treatment supports the notion of family homeostasis in anorexia and bulimia. Crisp et al [13] compared degrees of neuroticism of parents of anorexic patients with a control group before and after weight gain of their daughters. It was found that when their anorexic daughters' weight returned to normal, there was an increase in psychological turmoil in the parents. This finding was especially evident in the bulimic subjects.

Systems concepts regarding anorexic families have been most clearly delineated by Minuchin et al [1]. Minuchin and his coresearchers have postulated a group of family system characteristics that reflect the transactional dynamics of "psychosomatic families" of patients with juvenile onset diabetes mellitus, bronchial asthma, and anorexia nervosa. One such characteristic is *enmeshment*, a transactional style where family members are overinvolved with and overresponsive to one another. Each member develops poorly differentiated perceptions of one another and of themselves. Family members intrude on each other's thoughts, feelings, activities, and communications. There is extreme sensitivity among family members and minor upsets are responded to rapidly. Shifting alliances among family members are also observed. In some enmeshed families, one parent enlists a child's participation in a coalition against the other parent. This reflects a blurring of generational boundaries. This pattern hinders separation and individuation of family members. At times in the family life cycle it is necessary for a family to be enmeshed. For example, when an infant is born, there is a mutual overinvolvement between the parents and the newborn; however, if this extreme closeness continues to occur as the child grows, it delays the natural growth of independence within the child. A child growing up in an enmeshed family learns that loyalty to her family is of primary importance, and she may act in a manner to get approval from others as opposed to seeking self-approval. The parents in an enmeshed family are hyper-vigilant with regard to all the girl's activities. The anorexic girl's body seems to belong to the whole family, because so much energy is focused on it.

Another characteristic of the anorexic family is *over-protectiveness*, in which members have an extremely high concern for one another. Nurturant and protective responses are sought and supplied most of the time. Critical remarks are usually softened by soothing responses. Parental control over the children is the norm

in the anorexic family. In addition, anorexic children can be very overconcerned and protect their parents.

The third main characteristic is *rigidity*; these families tend to deny the need for change, and they preserve accustomed patterns of interaction and behaviors. Efforts at changing the family system by any member initiates a reverberation throughout that system to maintain the status quo and prevent change from occurring. The rigidity can be especially seen when the family cycle usually points to a need for accommodation to a natural change such as when an adolescent is requesting more independence. In anorexic families, it is found that family members insist on retaining accustomed methods of interaction. Because issues that threaten change are not allowed to surface, these families remain in an extreme state of prolonged submerged stress; however, they present themselves as normal except for their offspring's medical problems.

The fourth transactional pattern is *avoidance of conflict and lack of conflict resolution*. There is low tolerance for overt conflict within the family. Any discussion involving differences of opinion and issues of autonomy and control are avoided. Some eating disordered families deny the existence of any problems and are highly invested in concensus and harmony. Other psychosomatic families disagree openly, but constant interruptions and subject changes are used as a way to deflect or diffuse conflict. The resolution of these conflicts would require some degree of individual autonomy, which is gravely lacking in these families. Consequently, there is no utilization of any methods that can lead to the negotiation of differences. Problems are left unresolved and are perpetuated by avoidance maneuvers.

A fifth system characteristic is the role that the child or identified patient plays in the family's pattern of avoiding conflict. Viewed from a transactional point of view, the identified patient acts as a regulator in the family system. Often, in psychosomatic families, the symptomatic child is involved in parental conflict in different ways.

The typical patterns of child-parental overinvolvement are triangulation, parent-child coalition, and detouring. In the first two patterns, triangulation and parent-child coalitions, the spouses are in conflict with each other, and the identified patient is openly pressed to ally with one parent against the other. In *triangulation*, the child or identified patient is put in a position of splitting her loyalties to both her parents. She will not be able to express herself without siding with one parent against the other. In a *parent-child coalition*, the child tends to move into a stable coalition with one parent against the other. The third child-parent overinvolvement is *detouring*. In this pattern, both the spouses unite and blame or scapegoat their sick child. This maneuver

serves to deflect any sign of marital strife or even minor differences.

Minuchin's psychosomatic family model assumes that family structure does not independently cause a particular disorder. Organ dysfunction is present and the child or identified patient is physiologically vulnerable. This model includes a perspective that focuses on a biopsychosocial model of the development of a disease process. However, the paradigm focuses predominantly on familial influences.

In the case of anorexic families and psychosomatic families in general, it is characteristic that focus is on bodily functions. In families with an anorexic child, the whole family often has a special concern with such matters as eating, table manners, diets, and food fads (Minuchin, p. 61) [1]. Family interactional styles influence the child's health by acting as a catalyst in the production and maintenance of psychophysiological processes.

In order to test the generality of the above observations on the anorexic family as well as on psychosomatic families in general, a formal controlled study of these assumptions was conducted by Minuchin[1]. Forty-five families were studied. Three psychosomatic groups were included; eleven families with anorexics, ten families with asthmatics, and nine families with psychosomatic diabetic children were included. Two control groups were also used. Eight families were included where diabetes was under medical control; however, this group manifested behavioral problems. In addition, seven families with "normal" behavior or nonpsychosomatic diabetes were included in the study.

Minuchin and his colleagues set up a standardized interactive task for each family. Each session was videotaped and at a later time scored by independent raters on operationalized constructs of enmeshment, overprotectiveness, conflict avoidance, and rigidity. In general, the results of this part of the study indicated that the more dysfunctional families were more extreme on the above dimensions compared with the normal control groups. In addition, the anorexic families showed the most extreme patterns compared with the dysfunctional family contrast groups.

A second part of the study involved setting up live family diagnostic interview where the interviewer first induced stress in the marital dyad beyond its usual tolerance level and then brought only their psychosomatic offspring into the room. This task was set up to be able to observe systematically the role that the child played in detouring parental conflict. The results indicated that the parents of the psychosomatics tended to be more extreme on avoiding conflict and indeed used detouring mechanisms on to the child more often than did the con-

trast groups. The anorexic groups appeared to be the most extreme in diffusing conflict and by focusing on their offspring.

It should be noted that the above reported research study does not describe in detail how the transactional constructs were operationalized or rated. In addition, no statistical analyses were reported. In sum, although Minuchin and his colleagues describe their controlled research, this major study remains largely an anecdotal account of the psychosomatic family. Without a detailed critical account of how the transactional constructs were operationalized, rated, and statistically analyzed, one cannot scientifically objectively judge the outcome of the results.

Minuchin and colleagues also conducted a simultaneous physiological experiment with a sample of the diabetic children and their families during the live family diagnostic interview. Before these experiments it was found that the children who had exacerbations in their diabetic conditions showed a higher degree of free fatty acids (FFA) in their blood. FFA can be used as a biological marker for emotional arousal. During the live diagnostic family sessions, blood samples were drawn from both the parents and the diabetic child. As the interviewer induced conflict in the marital dyad, there were increases in the FFA level in both spouses; however, when the diabetic child entered the interview room, the parents' FFA levels decreased, and the child's increased. In fact, it was reported that the child's FFA level continued to increase after the induced stress in the marital couple subsided. Overall, the psychosomatic groups showed a greater significance of sensitivity to family conflict compared with the contrast groups.

These results were said to give further evidence of the role of the psychosomatic child in the context of his family. It is suggested that these physiological results support the concepts of parental protectiveness and reinforce family homeostasis. With the psychosomatic child's FFA level continuing to rise after the marital stress was alleviated, it was suggested that the psychosomatic symptom is maintained within the family system dealing with unresolved family conflict.

Although the above physiological study reinforces the psychosomatic family paradigm, the study can be criticized due to the small number of subjects. In addition, diabetics were used to generalize these patterns with anorexic families as well as all psychosomatic families in general. This indeed may not be the case. Other physiological studies within a systemic paradigm are needed to show further evidence of the interrelationship between psychosomatic illness and family dysfunction.

Selvini-Palazzoli [17], an Italian psychiatrist, worked with anorexic families at the Milan Center of Family

Studies. She observed family system characteristics similar to those described by Minuchin. She reports that communication patterns are extremely faulty; family members discount messages sent by others. The parents are described as unwilling to take responsibility or a leadership role; each parent tends to blame faulty decisions on the other. Blame can radically be shifted from one member to another. For example, mothers are said to blame their inability to help with decision-making on her overinvolvement with taking care of the children. All decisions are viewed as "for the good" of another (p. 209). Selvini-Palazzoli states that each parent feels victimized and views his or her position in the family as a personal sacrifice to the family. She describes the children in this family acting as a buffer for parental disharmony. She calls this state of affairs a "three way matrimony" (p. 211). The child is said to be more focused on her parents than her own individual development. When the anorexic child attempts to separate, the parents act to block this out to aid in maintaining homeostatis processes.

BULIMIC FAMILIES

Although there have been many anecdotal reports on family systems characteristics of the anorexic, there is a paucity of literature on bulimic family systems.

Schwartz [28] reports a family therapy case of an identified patient who is a 17-year-old normal-weight bulimic female. This reported case is a part of an outcome study of family therapy with bulimics. Schwartz reports that the bulimic families' structure was not hidden, unlike many anorexic families. He states that one could observe the distress in the family through the open criticism toward the identified patient. The mother and the identified patient, at times, would form a coalition against the father. At other times, coalitions shifted with the identified patient and father allied against the mother. It is interesting to note that Schwartz' description of more open criticism in bulimic families has also been reported in families of drug addicts and abusers. But drug-abusing families show more detouring-attacking mechanisms instead of the detouring-protecting patterns in the anorexic restrictor families [29]. It is easy to understand how parents could be more overprotective with a daughter who appears like a skeleton as opposed to a self-indulgent child. Both detouring-attacking and detouring-protective processes serve as homeostatic mechanisms to deflect marital tensions. Although some similarities exist between drug abuse and the bulimic family populations, these need to be further researched.

Lemberg and Bohanske [30] contrasted the anorexic restrictor, anorexic-bulimic, and normal-weight bulimic family system with one another. Their observation

through case study suggests that anorexic-bulimic families are more conflict ridden than the conflict-avoidant pattern in the restrictor anorexic population. They categorize the anorexic-bulimic families as more disjointed and less cohesive. In addition, they view the family structure as being more chaotic. In contrast, with the anorexic-restrictor group, the anorexic-bulimic's symptoms are less protective of family conflict, but more a "protest." The bulimic behavior is depicted as a symptom that reflects the general chaos in the system and the lack of system response to the developmental needs of the adolescent or young adult. Lemberg and Bohanske state that the anorexic bulimic patients remain enmeshed in the chaotic family process whether living in or out of the home. They also state that the family's chaos is reflected in the finding that the families are unavailable because of divorce, distance, or general family discord. Lemberg and Bohanske also compare the normal-weight bulimic to the restrictor anorexic and the anorexic-bulimic groups. They state that the family system model appears less applicable in the normal-weight bulimic groups. They state that, although unresearched, bulimic symptoms in normal-weight individuals appear to occur in patients who have good premorbid family adjustment. However, they state that these women are currently under psychological stress that is related to the young adults' developmental period and not to the family of origin's system. He concludes that bulimic behavior appears to be activated more in the social context with conflict around intimacy and peer relations. This concept contradicts the family systems notion that the bulimic symptom is embedded in the family context and helps the family to maintain a homeostatic equilibrium. Thus, Lemberg and Bohanske appear to be extending some bulimic symptomatology to reflect individual psychopathology that is separate from the family system.

Gawelek [31], in her case study of five binge-purgers, found the daughters to perceive their families as "ideal," but relationships were conflicted and strained. There were also reports of more open conflict with the mother [18,31,32]. In contrast with the anorexic, the bulimic rebels during her development, with increased dissension at adolescence. In contrast, anorexics are cited as harboring repressed hostile feelings toward the mother, although, on the surface, mother-daughter relations appear to be nonproblematic or conflicting.

Hicks [33] studied 24 bulimic women who met DSM III criteria for bulimia through a questionnaire and semistructured interviews. One of the main goals in the study was to investigate the bulimic perceptions of their family of origin. The average age of the women was 28.25 years. Although all the women met DSM II criteria for bulimia, five of the subjects had anorexia during their adolescence. The majority of subjects reported

their parents' marriage as unhappy, frustrated, and full of unresolved conflicts. There was evidence of stable coalitions between mother and daughter against father or some third person, usually a grandparent. Although there was overinvolvement between mother and daughter, the relationships were cited as highly ambivalent. There were reports of conflict-avoidance patterns between mother and daughter; however, there were also reports of open fighting and expressions of conflict without resolution. Fathers were perceived as unavailable and uninvolved with home life. Fathers were described as being unavailable in terms of work involvements, alcoholic abuse, and physical or psychological ailments. Fathers were also reported to be prone to outbursts of temper as well as actual incidents of physical abuse. There were some instances that daughters reported being fearful of their fathers. Some of the subjects in Hicks' sample felt they had to cater to their father's narcissistic needs. Overall, women were mixed in their description of childhood closeness with their fathers. Although fathers were reported as being unavailable, descriptions of paternal figures indicate a strong presence in the lives of bulimics (p. 156).

Other researchers cited fathers of bulimics as possessing a high degree of obsessionality and problems with impulse control [22]. While fathers of anorexics are seen as peripheral to the system, the same studies indicate the binge-purger's father may be the object of "hero worship" [8]. He is similar to the anorexic father who places high value on achievement. Gawelek [31] also reports an emotional closeness between bulimic women and their fathers. The closeness in their relationships are remembered in childhood; however, bulimics perceive their fathers to be more distant and peripheral with the onset of puberty.

Hicks [33] reports that leaving home for bulimics was wrought with difficulties; often these would be times when severe binge-purge episodes would occur. Many of the subjects reported that there was an increase of turmoil in their parents' marriage when they left home resulting, at times, in separation or divorce. Other subjects reported increased psychiatric symptoms in the parents, usually with the father who showed an increase in alcohol consumption and affective disorders.

Hicks also reported sibling relationships of bulimics as being highly competitive, usually with brothers.

Roots, et al [45] in their recent book entitled *Bulimia: A Systems Approach to Treatment*, anecdotally describes three types of bulimic families that they have observed clinically: the perfect family, the overprotective family and the chaotic family. The perfect and the overprotective families reflect the anorexic restrictor family found in Minuchin's early research. On the other hand, the

chaotic family has characteristics similar to their anorexic restrictor counterparts such as enmeshment and lack of conflict resolution. However, the chaotic bulimic families have been observed to have more inconsistent rules and greater expression of open anger and conflict.

EMPIRICALLY BASED STUDIES ON FAMILY SYSTEMS OF ANOREXICS AND BULIMICS

Empirical-controlled studies on family systems and eating disorders are scarce. Sonne [34] cites Sabovich's study that systematically examined anorexic's parents' dependency, insecurity, boundary difficulties, and maladaptive management of sexual and aggressive impulses through the use of psychological measures. Sabovich matched the sample of anorexic parents with other parents of emotionally disturbed outpatient and inpatient girls. Results suggested that the parental dyad of anorexics exhibited more insecurity, dependency, and difficulty with impulse management compared with all other contrast groups.

Sonne [34] also reported a study by Sonne and Goldstein using the same populations as Sabovich. The research explored the extent of overinvolvement exhibited between family members in a simulated interaction. The simulation involved each parent role playing with his or her daughter as if she were in the room. Parental communications were coded for "acknowledgment," "direction," or "projection" of the child's inner state. Mothers of anorexics pointed to a communication pattern of high direction and low acknowledgment compared with mothers in the contrast groups. Anorexic fathers showed a mixture of roles including a passive-peripheral role, and at times, a more active, subtly intrusive role.

Another empirical study by Sonne [34] investigated transactions in family systems that had an anorexic offspring. She focused mainly on studying the pattern of enmeshment and conflict avoidance patterns in these families. Her sample included 11 anorexic female inpatients, five of other inpatient emotionally disturbed adolescents, and 27 outpatient emotionally disturbed teenagers. In order for the subjects to be included in the study, both mothers and fathers needed to participate in the research. The interactions focused on mother-daughter and father-daughter dyads. These dyadic interactions involved a discussion of a problem area that was of mutual concern. The interactions were tape recorded, and the session was transcribed on paper. The transcription was then coded on the degree of intrusiveness, evasion, and disagreement. The results were the opposite of those hypothesized. Anorexic families showed less intrusive or enmeshed behaviors compared

with the other contrast groups. This was due to low parental intrusion; however, anorexic adolescents were seen as equal or more controlling toward parents contrasted to the other adolescent comparison groups. In addition, the anorexics made more inferences about their parents' feelings, attitudes, opinions, motives, or behaviors without checking out if these perceptions were valid. Anorexic families in this study did show a significantly higher conflict-avoidant pattern in mother-daughter interaction compared with contrast groups. However, the characteristics of conflict avoidance between father-daughter dyads was not significantly different from comparison groups. Sonne noted that anorexic adolescents in part tried more than controls to engage their fathers in a more personal interaction. However, compared with controls, anorexic fathers tended to distance themselves from their daughters when they tried to push for more involvement. Overall, there was a more diversified transactional pattern between father and anorexic daughters as compared to mother-anorexic dyadic sequences.

Sonne's results of less enmeshment in anorexic adolescents contradicts Minuchin's findings. She discusses these results and offers explanation. She states that the operationalized behavior she used perhaps did not truly match up with the construct of enmeshment. In addition, her control groups differed from Minuchin's; they were composed of other emotionally disturbed adolescents in comparison with Minuchin's use of other psychosomatic physically ill and "normal" groups. Another confounding variable was the emphasis on conflict in experimental interactions. Consequently, Sonne thought this may have actually produced a tendency for the dyad to increase the avoidance of conflict, thus, creating an illusion of harmony. However, it is in this writer's opinion that the dyad was not stressed enough to see the enmeshed patterns become amplified. It should be noted that Minuchin actually induced a crisis in the family for change to occur. At these times, one could clearly see the enmeshed and conflict avoidance patterns in these families.

Sonne [34] compared a subset of her anorexic patients who were additionally bulimic and compared them with the other anorexic restricters. Results indicated three of the four anorexic nonrestricters showed patterns of both high intrusion and high disagreements with their mothers. No correlation between bulimic symptoms and level of disagreement were apparent. Sonne hypothesizes that the pattern of greater intrusion and conflict may be evidence of extreme ambivalence with both dependency and hostility being acted out. In addition, the greater ambivalence in the bulimic group may lead to a greater amount of conflict expression without resolution.

Yager [23], in a preliminary pilot study, compared more than 30 anorexic and anorexic-bulimic patients, age 20, using the Family Environment Scale. When he administered the test separately to each parent and patient, each person reported a very different family environment. However, these data were not statistically analyzed.

Garner et al [35] compared groups of 59 restricter and nonrestrictor anorexics with normal-weight bulimics on a family assessment scale that measures task accomplishments, role performance, communication, affective expression, affective involvement, control, and value and norms. They report an extremely high similarity on all of the subscales for both the anorexic-bulimic and normal-weight bulimic groups. The scores on the family measures, except for role performance, indicated more severe pathology in both the bulimic groups compared with the anorexic restrictor group.

Strober [36] administered two family measures to the parents of anorexic and anorexic-bulimic patients. Each set of parents jointly completed the Moos Family Environment Scale (FES) [37] for the purpose of describing family patterns before the onset of their daughter's eating disorder. The parents also completed the Locke Wallace short marital adjustment test [38].

On the FES, anorexic-bulimic families showed significantly higher levels of conflictual interactions and expressions of negativity among members; in contrast, anorexic families were associated more with greater cohesion (ie, mutual support and concern among family members) and organization (ie, clarity of structure, rules, and division of responsibilities). On the marital adjustment scale, disharmony was found in both groups; however, significantly higher levels were reported by parents of anorexic-bulimics compared with anorexics.

Strober matched his two samples on age (\bar{x} years = 15.7) and duration of illness (\bar{x} months = 11.9). However, he did not match his samples with a normal control groups. If one compares Strober's findings with the normative data for normal families cited in the FES manual, there are contradictions that exist between Strober's results and the majority of system theorists' observations of anorexic families. Anorexic families perceived themselves as significantly higher on cohesiveness than anorexic-bulimics; however, anorexic-bulimics scored lower on the cohesiveness scale when compared with FES normal family groups. According to Minuchin's theory, dysfunctional or symptomatic families would be seen on the extremes of the cohesiveness dimension. Minuchin labels extremely high cohesion as enmeshment and extremely low cohesion as disengagement. Both of these extremes are considered dysfunctional. Functional normal families are cited as having a balance on the enmeshment-disengagement

continuum. Therefore, one can conclude that Strober's results showed that the anorexic-bulimic families were more disengaged. This finding contradicts Minuchin's theory as anorexic families are viewed as all enmeshed or extremely cohesive.

Another contradiction between Minuchin's structural theory and Strober's research findings is that on the FES conflict scale (extent to which the open expressions of anger, aggression, and conflictual interactions are characteristic of the family) is that both anorexic and anorexic-bulimic groups are seen as higher than normals on this dimension. According to Minuchin's theory, all anorexic families would be more extreme on conflict avoidance than functional-normal families.

A critical evaluation of Strober's study shows several confounding variables. Family measures were administered and analyzed from only the parents' perspective; different scores could have been obtained if the identified patient's responses were analyzed, since her perception of her family could be markedly dissimilar from her parents'. In addition, parents were asked to fill out the FES retrospectively, before their daughters' symptoms. Since the mean time between onset of symptoms and hospitalization was 11.9 months, perceptions of the family environment could have been distorted. Another weakness of Strober's study was the absence of a normal matched control group. This would be important in order to more fully understand and illuminate theoretical notions between functional and dysfunctional families.

Another weakness of Strober's study is the use of only the FES to measure family structure. Epstein et al state that the instrument is a research-oriented assessment tool and therefore may not be applicable to clinical populations [39].

Kramer [40] studied the family systems characteristics of anorexic restricters, anorexic-bulimic, and normal-weight bulimic and compared them with a normal-weight control group. Two paper and pencil tests were used in the study, including the Family Environment Scale [37] and the Structural Family Interaction Scale [41]. In addition, an eating behavior survey was employed to assess the degree of bulimia and/or anorexia nervosa as well as other miscellaneous behaviors. An overall sample of 60 family triads consisting of mother, father, and daughters were used in the study. Eight anorexics, 20 anorexic-bulimics, 18 normal-weight bulimics, and 14 controls were included in the sample. The groups were matched on age (mean = 20 years), socioeconomic status (mean family income = \$35,000), and family size (mean = five members). All of the subjects met criteria for the diagnosis of eating disorders as defined by the DSM III (modification in anorexic restricter

group had to be at least 15% below normal weight using insurance charts). Anorexic bulimics and normal-weight bulimics were also matched on severity of symptoms. All binged and vomited at least once a day. Most of the eating disordered subjects had been in some type of individual treatment in the past, but most of the samples were no longer currently engaged in therapy. All eating disordered subjects were recruited from outpatient therapists and self-help groups in the Southern California area.

Kramer [40] found that, in general, all the eating disorder groups were more similar than different on family systems characteristics. In addition, the eating disorder groups showed more dysfunctional family patterns than a normal control group. The anorexic-bulimic group yielded more dysfunctional patterns than the other contrast groups. Anorexic-bulimics perceived more mother overprotection, father overprotection, mother neglect, and less flexibility, mother-child conflict resolution and independence compared with anorexics, normal-weight bulimics, and controls. Anorexic restricters perceived the least parent management and the greatest triangulation maneuvers (each parent actively trying to get their daughter to be in coalition against the other parent) compared with anorexic-bulimic, normal-weight bulimic, and control groups. Another finding was that the general ordering of the contrast groups, in terms of the most to the least family dysfunction were the following: anorexic-bulimic, normal-weight bulimic, anorexic, and controls.

Kramer's study also yielded significant correlation coefficients suggesting that a relationship does exist between the type, severity, frequency, and/or set of bulimic symptoms and family systems variables. For example, Kramer found that the rapid intake of food was associated with the higher family rigidity and achievement orientations. In addition, the greater the amount of foods eaten during the binge, the less the family flexibility; and the greater the family's intellectual orientation, the greater the frequency of self-induced vomiting. These findings may reflect how bulimic symptomatology helps to maintain chronic predictable patterns in the family system for homeostatic purposes. In addition, bulimic symptoms may represent a rebellion on the daughter's behalf to try to escape from family control and embedded values such as achievement and intellectualization. In addition, bulimic symptoms could be viewed as the daughter's manner in which she deals with her ambivalence over dependence versus independence.

Overall, Kramer's findings were consistent with Minuchin's psychosomatic paradigm. His findings also extend Minuchin's family systems model to include an-

Table 14.1 Summary of the Eating Disorder and Family Characteristics From Different Researchers

Researcher	Anorexics	Anorexic-Bulimics	Normal-Weight Bulimics
Boskind-Lodahl (1976)	Father pressures for high achievement Less involvement with father	—	Father pressures for achievement Father is worshipped as hero figure
Minuchin (1978)	Extremes on: Enmeshment Overprotection Conflict avoidance Rigidity Parent-child coalition Triangulation Detouring (Protective)	No different than anorexics	—
Gawelek (1979)	No rebellion during adolescence Conflict avoidance especially with mother	—	High control — rebels during adolescence Conflict expression, especially with mother
Sonne (1981)	Less enmeshment compared with other psychiatric groups Greater conflict avoidance compared with other psychiatric groups Fathers more peripheral	More enmeshment or high intrusion High levels of disagreements	—
Strober (1981)	Extreme on cohesion, and organization Less conflict, and expression	Less cohesion Less organization More conflict expression	—
Hicks (1982)	—	—	Stable coalition between mother and daughter — although relationship; highly ambivalent Distant fathers — both conflict avoidant and open conflict expressed (Sample — mixture of normal-weight bulimics and anorexic-bulimics)
Lemberg (1982)	More cohesion More conflict avoidance More rigidity	Less cohesive (but enmeshed) More conflict expression More chaos	Good pre-morbid Family adjustment
Schwartz (1982)	Conflict avoidance More mother-child coalition	—	Conflict expression without resolution More father-child coalition
Yager (1982)	No significant difference between anorexics and anorexic-bulimics	—	—
Kramer (1983)*	Less parent management and more triangulation compared with anorexic bulimic, normal-weight bulimic, and normal controls	More mother overprotection, father overprotection, mother neglect, rigidity (less flexibility), less mother-child conflict resolution, less independence compared with anorexics, normal-weight bulimics, and normal controls	
Garner and Garfinkel (1985)	Overall less severe family pathology	Both anorexic-bulimics and normal-weight bulimics greater family pathology	

Table 14.1 Summary of the Eating Disorder and Family Characteristics From Different Researchers (continued)

Researcher	Anorexics	Anorexic-Bulimics	Normal-Weight Bulimics
Kog, et al., (1985)** Humphrey (1986)		Anorexic-Bulimics greater isolation, detachment, conflict, less involvement compared to normal controls	
Casper (1986)		Anorexic-Bulimics greater intrusion compared to anorexic restrictors	
Root, et al.***			

*Overall, all eating disorder groups in general are more similar than different and all eating disorder groups in general are greater than normal controls. All results taken from Daughter's Perception of Her Family System.

**No consistent pattern profile among eating disorder groups.

***All eating disordered groups similar in enmeshment, triangulating, and lack of conflict resolution — bulimic families consist of perfect and protective configurations that are similar in anorexic restrictors. However some bulimic families have more chaos — less organization and more open conflict.

orexic subtypes; bulimic families, in general, are more dysfunctional in interactive style than the anorexic restrictor family type.

Kog, et al [42] investigated Minuchin's psychosomatic family model through a pilot study of 10 families with both anorexic and bulimic patients. They utilized a series of in vivo standardized interactional tasks. The families were rated through paper and pencil measures as well as observational data via videotape. The researchers measured enmeshment, rigidity, overprotection and lack of conflict resolution.

The preliminary results of the Kog, et al study was that they did not find a specific or consistent interactional pattern. However, it should be noted that the subjects were heterogeneous including age ranges of young teenagers (mean age - 16) through young adults (mean age - 20). In addition, they studied mild and severe cases of eating disorder symptoms. Kog, et al criticize Minuchin's paradigm as being limited conceptually and methodologically.

Humphrey [43] compared patterns of family reactions in 16 bulimic-anorexic and 24 non-distressed family triads. The study used paper and pencil tests including the Family Environment Scale (FES) and the Family Adaptability and Cohesion evaluation scale (FACES). Each individual of the family triads including father, mother and daughter were tested. Results indicated that the bulimic-anorexic families experienced greater isolation, detachment, conflict, less involvement and support than did controls. The author concluded that bulimic-anorexic families seemed more hostile, and chaotic than they did overprotective, and over-involved

as had been reported for anorexic restrictor families.

Casper [44] compared anorexic bulimics to anorexic restrictors. Her preliminary results indicated that the anorexic bulimic families were more intrusive compared to the anorexic restrictor group.

CONCLUSIONS

In summary, there are contradictory findings and observations between anorexic subtypes and family interactive styles. Table 1 gives a summary of all the eating disorders groups and corresponding family systems characteristics from different research previously discussed.

Many factors contribute to the variability of findings across eating disorder groups. Many studies have limited generalizability because of the small numbers in their sample. In addition, many studies recruit subjects who volunteered; therefore, subjects may have not been a true representation of all anorexics and bulimics. Many of the bulimics are secretive about their eating behavior, and those bulimics may be different from ones who are studied. Another problem when trying to synthesize and integrate findings between different studies is whether the subjects are inpatients or outpatients. Hospitalized patients may show different family characteristics (ie, more chaotic patterns) compared with non-hospitalized patients. A similar issue has to do with comparing studies that use subjects with varying degrees of severity of symptomatology. For example, Garner's study showing more equal extreme dysfunction in both anorexic-bulimic and normal-weight bulimic compared

with restricter anorexics is inconsistent with Kramer's study where there were more similarity between all anorexic subtype groups on family characteristics as well as the anorexic-bulimic group showing the greatest degree of family dysfunction. The sample that Garner used appeared to be eating disordered groups that were more chronic and severe in their symptoms. Another limitation on issues of generalizability is due to age difference in samples studied. For example, Minuchin's sample was mainly composed of young adolescent females. In other studies (ie, Garner, Kramer, Kog), the mean age was significantly higher.

Another methodological problem that adds to difficulty in assessing family systems is that many studies use self-report measures that involve individual member's perceptions of their family functioning. One's perception of one's family organization could be very different from researchers who used observational data (ie, Minuchin).

Patterns of research such as Kog, et al need to be continued. Research is needed to break down many confounding variables to distinguish family system characteristics of anorexic subtypes from one another. Future studies could focus on comparing inpatient and outpatient populations, different age-groups, as well as intact and broken families with one another. Last, it would be highly desirable, although quite cumbersome, to design a study to assess the family structure through the use of videotape. Independent raters could score the family on a number of dependent variables and compare these results to self-report measures. This would allow family researchers to see if paper and pencil measures correlate with observations of family structure. The would also control for reporter bias and social desirability as confounding variables. In addition, it would give a great deal more validity to the assessment tools.

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