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Anorexia nervosa: A family systems perspective

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Abstract

Anorexia Nervosa is primarily a disorder of the adolescent female. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-111-R) (American Psychiatric Association, 1987), the age of onset is usually early to late adolescence (12-18), although it can range from prepuberty to the early 30s (rare) with a gender-specific psychopathology of 95% female. The cardinal feature of anorexia is the relentless pursuit of thinness, often leading to life-threatening weight loss. This pursuit of thinness becomes associated with intense fears about eating, gaining weight, getting fat, and losing control over food intake. A mortality rate between 5% and 18% is indicated by DSM-111-R studies.

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Anorexia Nervosa is primarily a disorder of the adolescent female. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) (American Psychiatric Association, 1987), the age of onset is usually early to late adolescence (12-18), although it can range from prepuberty to the early 30s (rare) with a gender-specific psychopathology of 95% female. The cardinal feature of anorexia is the relentless pursuit of thinness, often leading to life-threatening weight loss. This pursuit of thinness becomes associated with intense fears about eating, gaining weight, getting fat, and losing control over food intake. A mortality rate between 5% and 18% is indicated by DSM-III-R studies.

According to Bruch (1973, 1978), the disorder begins innocently: a young girl goes on a simple diet, but before long the diet is out of control. Whereas at first she may have received praise for her weight loss, friends and family soon criticize her looks and try to get her to eat. The anorexic shuns advice--usually thinking others are trying to make her fat--and becomes more determined in her desire to lose weight. She is usually unaware of her extreme thinness; even if she recognizes it, her intense fear about getting fat prevents her from changing the anorexic behavior that has become dominant in her life.

The interaction between physiological and sociocultural factors is the basis for anorexia being a gender-specific psychopathology. According to Beattie (1988), women's vulnerability to this disorder derives at least in part from early female psychosexual development. Furthermore, the early process of separation-individuation from the all-powerful pre-Oedipal mother is enormously more difficult for girls than for boys, since girls must simultaneously individuate and identify with a primary caretaker of the same sex. Consequently, Beattie postulates, hostile-dependent conflicts and ambivalent struggles for autonomy from the mother may persist life-long in women and are all too easily acted out via abnormal control of food intake and body shape.

Girls in our culture, unlike boys, are socialized to gain a much higher proportion of self-esteem and social acceptance from their physical appearance (Beattie, 1988). In addition, standards of female appearance have been changing markedly in the past 20 years when a leaner, prepubertal, boyish look came to be admired. These trends run counter to the natural physiological characteristics of women, who have a higher proportion of body fat than men as well as a lower resting metabolic rate and who tend to gain fat throughout the life cycle, especially at puberty and with successive pregnancies

(Striegel-Moore, Silberstein, & Rodin, 1986). It is thus plausible that women's attempts to diet and maintain unrealistic low weights in conformity with the dictates of fashion can frequently lead to episodes either of self-starvation or semifasting punctuated by food craving and episodic binge eating.

The purpose of this paper is to examine the research available on the families of anorexics to discover if there is a "typical anorexic family profile." Along with reviewing trends in families of anorexics, the paper covers the symptoms of the anorexic according to the DSM-III-R, the common personality disorders and characteristics of anorexics, and the etiology of anorexia. The paper briefly reviews the multidimensional approach to treatment with the emphasis being on family therapy.

Diagnostic Criteria

Anorexia is classified in the Diagnostic and Statistical Manual of Mental Disorders devised by the American Psychiatric Association. The following are the diagnostic criteria for anorexia as stated in the DSM-III-R (1987):

A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight 15% below the expected: or

failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight, size, or shape is experienced, e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight.

D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration) (p. 67).

In addition to these criteria, Eckert (1985) included denial or failure to acknowledge the anorexic illness and hyperactivity as being other clinical features.

Personality Disorders and Characteristics

In the DSM-III-R Criteria (American Psychiatric Association, 1987), the most common personality disorder of the restricted anorexic is avoidant, and the most common disorder in the bulimic

anorexic is borderline (Piran, Lerner, Garfinkel, Kennedy, & Brouilette, 1988). Similarly, when the three clusters of personality disorders suggested in the DSM-III-R were employed by Piran et al., 77% of restricters fall within the avoidant, obsessive-compulsive, dependent, and passive-aggressive, and 66% of the bulimics fall within the borderline, histrionic, narcissistic, and antisocial. These percentages support the employment of avoidance and withdrawal and the inhibition of action within the restricting group and the employment of impulsive discharge through action in the bulimic group. In addition, on the Minnesota Multiphasic Personality Inventory, the restricted anorexic and the bulimic anorexic were found by Piran et al. to have a similar profile reflecting character pathology with increased depression, anxiety, poor concentration, feelings of resentment, and alienation. Similarly, Soukup, Beiler, Terrell (1990) reported that anorexic individuals have a lower level of self-confidence, are more prone to depression, and are somewhat anxious. These results do not make it possible to discern whether personality and cognitive variables predispose individuals toward an eating disorder, yet there does seem to be a personality profile that correlates with eating disorders.

Predominant premorbid personality characteristics of an anorexic include being "very well behaved," perfectionistic, and

competitive and achieving, resulting in above-average performance in grade school and high school (Eckert, 1985). Heibrun and Harris (1986) proposed stress to be a predisposing condition in anorexic women, especially stress in areas of academic achievement, failure in goal attainment, broken personal relationships and/or growing up in a high competitive atmosphere. Furthermore, they found that female concerns that produce stress are found to be rooted in the persistent strain of anticipated problems in the escalating conflict over traditional (marriage/family) and contemporary (career) options. These conflicts are seen as incompatible and involve sacrifices and losses for the preanorexic female. Heibrun & Harris also found that stress is less tied to current life events than to future concerns about her womanhood--physical appearance, adult sexuality, and sex-role behavior. Furthermore, these authors found that the young female depends upon evasive defenses of repression and cognitive strategies to escape chronic stress from something as unpredictable and unmanageable as her future as a woman in today's society. She not only uses repression as a defense, but is unaware of her repression and combines repression with a narrow internal scanning of information (Hebriun & Harris, 1986; Soukup et al., 1990).

Etiology

According to Josephon (1985), anorexia nervosa begins as a solution to a developmental conflict centered on the mastery of four universal adolescent tasks: identity formation, separation from family and coming to terms with one's feelings about the family, development of mature love relationships, and learning control of one's body. Many clinicians have emphasized the anorexic's inability to contend with the problems and opportunities of adolescence (Bruch, 1978; Selvini-Pallazzoli, 1978; Strober & Humphrey, 1987). These clinicians describe the anorexic clients as immature and as resistant to change, tenaciously clinging to the prerogatives of childhood. Consequently, wishing to return to their relatively uncomplicated earlier years, anorexics do not engage in activities appropriate to their age.

Strober and Humphrey (1987) noted that even though certain familial patterns are associated with anorexia, there is no single mechanism or pattern of influence. However, their research clearly verifies that anorexia nervosa runs in families. Furthermore, certain personality factors (e.g., neuroticism, obsessive worrying and rigidity, introversion), predispose the individual to greater sensitivity and vulnerability to powerful familial and social experiences that impinge

adversely on self-esteem and self-efficacy. On the other hand, the concentration of anorexia in families may have nongenetic origins, according to Strober and Humphrey. This explanation gives greater emphasis to the powerful role played by the home environment in shaping both adaptive and deviant patterns of self-esteem, identity, and coping behavior.

White (1983) linked the condition of anorexia nervosa with certain rigid and implicit family beliefs. These rigid and implicit beliefs are transmitted from one generation to the next and have a highly constraining effect on all family members. These beliefs include role prescriptions that are applied to certain daughters. When such systems of belief include the following aspects, the conditions are established for the denial of self and a vulnerability to the symptoms of anorexia nervosa in certain daughters (White, 1983):

1. A strong prescription for loyalty to other family members and to family tradition and a "currency of guilt" that checks any deviations from certain standards of loyal behavior, food being one of the vehicles for this currency.
2. A specific role prescription demanding extreme forms of loyal and devoted behaviors from certain daughters.

3. A belief in construction of reality dominated by "insightfulness." (p. 258-259)

Anorexic Family

There is great diversity of opinion about the effects of the family on anorexia nervosa. Bruch (1973) found parents of anorexics to be overprotective, overambitious, and preoccupied with outward appearance and success. Furthermore, these behaviors resulted in a failure to help the anorexic child to establish a sense of autonomy. In addition, Kog and Vandereycken (1989), noted that the anorexic family has interpersonal boundary problems and a stable and conflict-avoidant pattern of interacting, which is experienced as nonconflictual and cohesive by both the anorexic and her family. Similarly, Garfinkel et al., (1983) found that anorexics and their mothers perceive the family as having difficulty with task performance, role performance, communication, and affectional expression compared with control families.

Selvini-Palazzoli (1978) also noted that parents are overprotective, using covert alliances, blame shifting, impaired communication and poor conflict resolution. She placed the accent on a family pattern which is in a constant state of tension and frequently subject to numerous trivial arguments. Absent or distant fathers

complemented by overinvolved, dominant mothers, denied coalitions between anorexic child and parents, and a desire to be secretive and gloss over family problems, in order to keep up appearances, are also found to be observably repetitive patterns characteristic to the symptomatic family, according to Selvini-Palazzoli.

Minuchin, Rosman & Baker (1978) described anorexic families as "dysfunctional" and, further, found them to be supportive of the somatic expression of emotional distress. Minuchin et al. identified the dysfunctional characteristics as enmeshment, overprotectiveness, conflict avoidance, and poor conflict resolution. However, Harding and Lachenmeyer (1986) reported that when they compared anorexics with a control group in their mid-twenties, the two groups did not differ on overprotectiveness, enmeshment, and rigidity. Furthermore, Kog, Vertommen, & Vandereycken (1987) criticized Minuchin's conceptualization with regard to the overemphasis on the pathological extremes of the interaction features, with a consequent lack of attention to situational and temporal variables. Kog et al. redefined Minuchin's categorical characteristics in dimensional terms on a continuum on which every type of family interaction can be studied.

Strober and Yager (1985) noted variability in the family constellations associated with anorexia nervosa from a developmental

perspective. For them, the two dominant family patterns that are discernible and recurrent in the families of anorexics studied are "centripetal process" and "centrifugal process." The "centripetal process" is dominated by themes of excessive cohesion with relationships colored with a lack of permissiveness, reduced emotional expressivity, and impoverished extrafamilial contacts. In contrast, the "centrifugal process" lacks family cohesion and attachment which are characterized by high amounts of conflict previous to the onset of anorexia. The researchers noted that the centrifugal interactions are characterized by threats of abandonment, clinging dependency, and expressions of disappointment. This predominant theme of lack of control is recurrent in family relationships that are marred by openly expressed marital discord. In agreement, Yager (1982) noted marital discord in 50% of the cases of anorexia studied.

Garfinkel and Garner (1982) suggested that the families of anorexics are a heterogenous group. For them, there is no one type of family relationship or family structure unique to anorexia nervosa. Rather, from their perspective, there may be a number of risk factors or difficulties related to the family that may predispose a child to anorexia nervosa. However, they are set against a background of many other nonfamily related risk factors.

The results of a study by Grigg, Frieson, and Sheppy (1989) supported the views of Garfinkel and Garner (1982), cautioning against the use of terms such as "anorexogenic" and "anorexic family" and the use of uni-dimensional explanations such as those used by Minuchin et al. (1978) and Selvini-Palazzoli (1978).

Recently, Garfinkel, Garner, and Kennedy (1985) have noted some common disturbances in the interaction patterns of families with anorexic children related to communication, affective expression, expectations and role performance, but maintain that vast differences also exist in the families they have studied.

According to Yager (1982), family theorists have been criticized on grounds of observer bias, retrospective distortions, the lack of comparison samples of families, the small number involved in the studies and the inherent difficulty in distinguishing cause/effect. It must be noted that many of the family relations described may merely reflect change engendered by the starving child. However, it does reflect the reciprocal nature of family relationships. Dysfunctional family interaction both provokes anorexia nervosa and profits from it. Furthermore, Morgan and Russell (1975 noted that a significant number of interactional problems existed in these families before the

onset of anorexia nervosa. In addition, Yager (1982) and Josephon (1985) found that poor treatment results are associated with greater severity of relationships between parents and clients prior to onset of anorexia. Additionally, Yager documented that the functioning of other family members frequently deteriorates as anorexics gain weight.

"Typical" Personalities of Parents

Mothers of anorexics have been commonly described as intrusive, overprotective, anxious, perfectionistic, and fearful of separating from their children. Fathers have been commonly described as emotionally constricted, obsessional, moody, withdrawn, passive, and effectual (Bemis, 1978; Garfinkel & Garner, 1982; Strober & Humphrey, 1987; Yager, 1982). Humphrey (1989), using the SASB observational coding system, discovered that mothers and fathers of classical, restricting anorexics are more nurturing and confronting but also more ignoring and neglecting toward their daughters than are parents of normal controls or bulimics. Anorexic's daughters, in turn, are the most submissive toward their parents.

Mothers are described as "programming" their daughters (Bruch, 1973), as unable to see their daughter as separate (Selvini-Pallazzoli, 1978) and as subverting fulfillment of the child's needs by

emphasizing their own sense of what is appropriate (Bemis, 1978). These patterns of interaction inhibit the development of self-directed behavior and result in a child of "robot-like" obedience (Bemis, 1978). According to Selvini-Pallazzoli, underlying this obedience to parental expectations are feelings of self-doubt and an inability for self-assertion. In addition anorexics feel they have no will of their own and cannot initiate or influence things in any way.

According to Bruch (1973), the unempathetic, intrusive, and/or overprotective mother contributes to the development of a child's ego structure which is inadequate to the tasks of autonomy and self-regulation. This leads to a lessened capacity to monitor bodily states such as hunger and satiety, and a tendency to act out conflicts over independence and self-control via excessive control of the body and its food intake. Moreover, Hood, Moore, and Garner (1982) found external (I-E) orientation a characteristic of the anorexic which was found to be closely linked to directive-type interactions between mothers and daughters, rather than a relationship characterized by early independent expectancies, less intrusiveness, and more suggestions.

Yager (1982) cautioned about accepting the assumption that anorexia can be fully understood only when the earliest infant-mother

relationship has been strongly examined. In a study done by Yager, mothers-daughter relationships ranged from oversolicitous mothers with "very" attached daughters, to ambivalent relationships, to disciplinarian relationships, to rejecting relationships. He found no support for an "anorexogenic mother."

Humphrey (1989) indicated that fathers of anorexics and bulimics are relatively more watchful, managing, belittling and blaming toward their daughters. Daughters, in turn, show more sulking and appeasing toward their fathers. In addition, fathers of classical anorexics combine pseudoaffection and control (i.e., nurturing and managing) and pseudohelp and negation (i.e., helping and ignoring) when speaking to their daughters. The anorexic daughters show a predictably ambivalent response, according to Humphrey, and juxtapose pseudo-self-disclosure with submission.

However, many studies failed to find any consistent patterns of personalities or neurotic traits, concluding that the level of emotional disturbance are the same in families with other types of neurotic disorders (Garfinkel et al., 1983; Strober, 1981; Yager, 1982).

Treatment

As is indicated by the literature review, eating disorders are multidimensional. They have psychiatric, physiological, and social

components. Treatment must therefore take a multidimensional approach (Gilchrist, McFarlane, C., McFarlene, A., & Kalvey, 1986; Krey, Palmer, & Porcelli, 1989). Numerous treatment modalities have been advocated for these conditions, including individual, group, and family psychotherapies; psychoeducational groups; cognitive and behavioral strategies; and psychopharmacologic therapy. Such approaches are best provided by interdisciplinary treatment staff consisting of psychologists, social workers, counselors, nurses, nutritionists, and occupational, art, and recreational therapists.

Since the family interaction plays such a crucial role in the life of an anorexic, family therapy is used by many as one of the central types of treatment to use in the multidimensional approach (Krey et al., 1989; Gilchrist et al., 1986). By far the strongest empirical support for structural family therapy comes from a series of studies with psychosomatic children. Minuchin, Rosman, and Baker (1978) summarize the results of treating 53 cases of anorexia nervosa with structural family therapy as having a 90% improvement rate compared to the usual 30% mortality rate. The use of paradoxical directives in structural family therapy has proven to be a clinical breakthrough in treating anorexics (Selvini-Palazzoli & Viaro, 1988; White, 1983). There is evidence to suggest that, in human systems, directly to

challenge rigid and implicit beliefs or the organizational consequences is likely to have paradoxical effect of strengthening the beliefs.

Conclusion

Two important points emerge from the literature review. First, abnormal family interactions do appear to shape the psyche and delay development in young anorexic adults (Bruch, 1973; Garfinkel et al., 1983; Josephon, 1985; Kog & Vandereycken, 1989; Minuchin et al., 1978; Soukup et al., 1990; Strober & Yager, 1985) Additionally, clinical experience with families of anorexic patients suggest that these problems are more than a simple response to illness. Furthermore, the families of anorexics may be markedly defensive and display misunderstandings of adolescent developmental norms and willful resistance to change. Secondly, it seems likely that the family interactional factor is not necessarily specific, but rather permissive, for the development of anorexia nervosa in a child (Garfinkel & Garner, 1982; Grigg, Frieson, & Sheppy, 1989; Kog, Vertommen, & Vandereycken, 1987; Strober & Humphrey, 1987; Yager, 1982). Any claim to specificity of these patterns in anorexia nervosa must be carefully examined.

According to L. M. Stamp (personal communication, February 9, 1989), the incidence of diagnosed eating disorders has doubled in

the last 20 years, making it essential that research of treatment and preventative measures be given priority. The study of family interaction seems promising. Most clinicians in this literature review agree that the involvement of the family is an important aspect of the study and treatment of anorexia nervosa. Integration of psychodynamics theories and observations of family interaction promises the most complete understanding of the anorexic child.

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