AN EXPLORATORY STUDY OF THE FAMILIES OF BULIMICS FROM A SYSTEMS PERSPECTIVE

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Thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts in Clinical Psychology, University of Cape Town.

July 1986

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ACKNOWLEDGEMENTS

I would like to thank the following people who have contributed to this thesis:

Graham Saayman, my supervisor, for his involvement at a very practical level during the process of writing this thesis.

Leslie Swartz, who initially encouraged me to undertake this research and who gave further advice during the writing of this thesis.

Sally Swartz, who gave careful supervision of the final draft of this thesis.

Carol Phillips, who assisted in the location of subjects.

Juliana and Rebecca who typed this thesis.

The individuals and their families who participated in my research.

My family and friends for their support.

Chris, for your practical advice, support and friendship during the writing of this thesis. Thank you for everything.

Mick, for being there for me, even when I wasn't. I love you.

The H.S.R.C. provided financial assistance but the views expressed here are the author's alone and not those of the H.S.R.C. or any organisation.

ABSTRACT

Previous research into the families of eating disordered individuals appears to have focused almost exclusively on the families of anorexics. In view of the problems associated with the conceptualization of bulimia as a syndrome distinct from anorexia nervosa, it seems possible that research into the families of anorexics may have included the families of bulimics. Following the introductory overview of some of the literature on bulimia, highlighting the lack of diagnostic clarity in this area, previous research into the families of both anorexics and bulimics is reviewed. In view of the lack of documented research into the families of bulimics from a systems perspective, the present study aimed to explore these families' functioning.

Family functioning was assessed according to the McMaster Model of Family Functioning (Epstein and Bishop, 1981): clinical interviews with 13 bulimics provided qualitative data on their families' functioning: quantitative data were elicited from the family members of 10 of these bulimics by means of the Family Assessment Device (Epstein and Bishop, 1983). Clinical assessment of the families of bulimics reveals unhealthy family functioning. The ratings of all family members as well as those of the researcher indicate that there is familial dysfunction on all dimensions of family functioning. The main emphases in these families appears to be on instrumental issues, while affective issues are inappropriately handled. Discussion centres on the findings of the present study, which show some variance with the results of previous research into the families of anorexics; and an understanding of bulimia from a systems perspective is presented.

CONTENTS

ACKNOWLEDGEMENTS (i)

ABSTRACT (ii)

LIST OF TABLES (viii)

CHAPTER ONE: BULIMIA: REVIEW OF THE CURRENT STATE OF THE LITERATURE

1.1 Introduction 2

1.2 Concept and diagnosis 2

1.3 Clinical features 10

1.3.1 Demographic data 10

1.3.2 Onset 11

1.3.3 Binge-eating 12

1.3.4 Weight history 13

1.3.5 Weight control methods 14

1.3.6 Physical complications 15

1.3.7 Associated psychiatric features 16

1.4 Aetiology 17

1.4.1 Predisposing factors 18

1.4.2 Precipitating factors 19

1.4.3 Maintaining factors 21

1.5 Management 21

1.6 Prognosis 23

1.7 Comment 24

CHAPTER TWO: FAMILY ISSUES IN THE PATHOGENESIS OF EATING DISORDERS

2.1 Introduction 29

2.2 Overview 30

2.3 Demographics and family values 34

2.4 Family psychiatric history 39

2.4.1 Genetic factors 39

2.4.2 Other psychiatric illnesses 39

2.5 Dyadic relationships 43

2.5.1 The marital dyad 45

2.5.1.1 Family atmosphere 47

2.5.2 Parent-child relationship 48

2.5.2.1 Mother-daughter relationship 48

2.5.2.2 Father-daughter relationship 49

2.5.3 Limitations of the dyadic approach 50

2.6 The systems approach 51

2.6.1 Overview 51

2.6.2 Family systems perspectives 52

2.6.2.1 Palazzoli 53

2.6.2.1.1 Communication 53

2.6.2.1.2 Leadership and blame-shifting 54

2.6.2.1.3 Coalitions 54

2.6.2.2 Minuchin 55

2.6.2.2.1 Enmeshment 56

2.6.2.2.2 Overprotectiveness 56

2.6.2.2.3 Rigidity 57

2.6.2.2.4 Conflict 57

2.6.2.3 Crisp 58

2.6.2.4 Criticism of family perspectives 59

2.6.2.5 Norris and Jones 62

2.6.2.5.1 The family myth 63

2.6.2.5.2 The enmeshed dyad 64

2.6.2.5.3 The processing barrier within the patient 64

2.6.3 Psychometric assessment of families 65

2.7 Comment 68

CHAPTER THREE: METHODOLOGY

3.1 Introduction 71

3.2 Methodological issues 71

3.2.1 Retrospective method 71

3.2.2 Interview and self-report questionnaire 74

3.3 Subjects 78

3.4 Measures 84

3.4.1 The McMaster Model of Family Functioning 84

3.4.1.1 Description 85

3.4.1.1.1 Problem solving 87

3.4.1.1.2 Communication 88

3.4.1.1.3 Roles 89

3.4.1.1.4 Affective responsiveness 91

3.4.1.1.5 Affective involvement 93

3.4.1.1.6 Behaviour control 94

3.4.2 The McMaster Family Assessment Device (FAD) 96

3.4.2.1 Description 96

3.4.2.2 Scoring 97

3.4.2.3 Adequacy of instrument 97

3.4.2.3.1 Reliability and criterion validity 97

3.4.2.3.2 Social Desirability 98

3.4.2.3.3 Test-retest reliability and concurrent validity 98

3.4.2.3.4 Discriminative validity 99

3.4.2.3.5 Health/pathology cut-off scores 99

3.5 Procedure 102

3.6 Scoring 103

3.7 Statistical methods 103

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1 Results 106

4.1.1 Introduction 106

4.1.2 Quantitative analysis 106

4.1.2.1 Overall impression 106

4.1.2.2 Reliability of data 106

4.1.3 Qualitative analysis 109

4.1.3.1 General family functioning 109

4.1.3.2 Problem solving 110

4.1.3.3 Communication 114

4.1.3.4 Roles 116

4.1.3.5 Affective responsiveness 123

4.1.3.6 Affective involvement 125

4.1.3.7 Behaviour control 127

4.2 Discussion 131

4.2.1 Family functioning 131

4.2.1.1 Basic tasks 131

4.2.1.2 Developmental tasks 132

4.2.1.3 Hazardous tasks 135

CHAPTER FIVE: FAMILIES OF EATING DISORDERS: EVALUATION AND CONCLUSIONS

5.1 Introduction 138

5.2 Methodological issues 140

5.3 Bulimia: a systems perspective 145

5.4 Family functioning in bulimia and anorexia nervosa 147

5.4.1 Qualitative data 147

5.4.1.1 Problem solving 147

5.4.1.2 Communication 148

5.4.1.3 Roles 149

5.4.1.4 Affective responsiveness 149
5.4.1.5 Affective involvement 150
5.4.1.6 Behaviour control 151
5.4.2 Quantitative data 152
5.5 Summary and conclusions 153

REFERENCES 158

APPENDICES 174

Appendix 1: Media article 175
Appendix 2: Interviews with bulimics 176
Appendix 3: Letter to parents 183
Appendix 4: Family Assessment Device 184

LIST OF TABLES

TABLE		PAGE
1.	Diagnostic criteria for anorexia nervosa	3
2.	Diagnostic criteria for bulimic syndrome	6
3.	Subject Characteristics	81a,b
4.	FAD cut-off scores	101
5.	Mean FAD scores for all family members; family mean scores and CRS means for all dimensions	107

CHAPTER ONE

BULIMIA: REVIEW OF THE CURRENT STATE OF THE LITERATURE

1.1 Introduction 2

1.2 Concept and diagnosis 2

1.3 Clinical features 10

1.3.1 Demographic data 10

1.3.2 Onset 11

1.3.3 Binge-eating 12

1.3.4 Weight history 13

1.3.5 Weight control methods 14

1.3.6 Physical complications 15

1.3.7 Associated psychiatric features 16

1.4 Aetiology 17

1.4.1 Predisposing factors 18

1.4.2 Precipitating factors 19

1.4.3 Maintaining factors 21

1.5 Management 21

1.6 Prognosis 23

1.7 Comment 24

CHAPTER ONE

BULIMIA: REVIEW OF THE CURRENT STATE OF THE LITERATURE

1.1 INTRODUCTION

This chapter will present a brief overview of the literature on bulimia with particular focus on the controversy surrounding the conceptualization of the syndrome. The clinical picture of bulimia is also outlined together with a brief discussion of aetiological factors, management and prognosis.

1.2 CONCEPT AND DIAGNOSIS

Over the past few decades there has been a growing interest in eating disorders among both the lay population and mental health professionals.

While anorexia nervosa has for several years been accepted as a clinical syndrome with specific diagnostic criteria (Feighner et al, 1972), (Table 1), the syndrome of bulimia was first recognised as a clinical entity in 1980 (DSM - III, APA, 1980). Nevertheless, whether bulimia should be considered a syndrome separate from anorexia nervosa remains a controversial issue and the relationship between the two disorders is far from clear.

The symptoms of binge-eating, vomiting and purging have long been recognised as an aspect of the disordered eating habits of patients with anorexia nervosa. Abraham and Beumont (1982) quote Stunkard (1959) as having first described binge-eating in "obese" individuals. This finding was later substantiated by Bruch (1973), but binge-eating in "overweight" individuals has also been reported (Wermuth et al, 1977). Bruch (1973) as well as other researchers (Dally, 1969; Russell, 1970), (Table 1), had however also suggested that the symptoms of binge-eating and purging may occur in certain anorexics, and in 1972 Feighner et al's modified criteria for

TABLE 1

DIAGNOSTIC CRITERIA FOR ANOREXIA NERVOSA

Russell (1970)	Feighner et al (1972)	DSM-III (1980)
1. Behaviour leading to marked weight loss and nutrition. Always includes avoidance of "fattening foods"; may include self-induced vomiting, purgation, exercise. Occasionally may be bouts of overeating, but these are compensated for by subsequent vomiting or prolonged starvation. 2. Endocrine disorder leading to amenorrhea in women and commonly to impotence in men. 3. Fear of becomming fat; need to control food; overestimation of body weight. 4. Absence of other physical or psychiatric illness.	1. Age of onset prior to 25. 2. Anorexia with accompanying weight loss of at least 25% of original body weight. 3. A distorted, implacable attitude towards eating, food, or weight that overrides hunger, admonitions, reassurances and threats, eg. (a) denial of illness with a failure to recognise nutritional needs; (b) apparent enjoyment of losing weight with overt manifestation that food is a pleasurable indulgence (c) a desired body image of extreme thinness with overt evidence that it is rewarding to the patient to achieve and maintain this state, and (d) unusual hoarding or handling of food. 4. No known medical illness that could account for the anorexia and weight loss. 5. No other known psychiatric disorder with particular reference to primary affective disorders, schizophrenia , obssessive compulsive and phobic neurosis. (The assumption is made that even though it may appear phobic or obsessional, food refusal alone is not sufficient to qualify for obsessive-compulsive or phobic disease.) 6. At least two of the following manifestations: (i) Amenorrhea; (ii) Lanugo; (iii) Bradycardia (persistent resting pulse of 60 or less); (iv) Periods of overactivity; (v) Episodes of bulimia; (vi) Vomiting (may be self-induced).	A. Intense fear of becoming obese, which does not diminish as weight loss progresses. B. Disturbance of body image, eg. claiming to "feel fat" even when emaciated. C. Weight loss of at least 25% of original body weight, or, if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25% . D. Refusal to maintain body weight over a minimal normal weight for age and height. E. No known physical illness that would account for the weight loss.

anorexia nervosa included these symptoms in the diagnostic criteria for anorexia nervosa (Table 1).

Thus first studies to record binge-eating, vomiting and purging symptoms focused on these as an associated feature of anorexia nervosa, since the prevalence of these symptoms in many of the anorectic populations studied approached 50 % (Beumont et al, 1976; Casper et al, 1980; Garfinkel et al, 1980; Thompson and Schwartz, 1982; Hsu et al, 1980).

In 1976, Beumont and his colleagues pursued an earlier suggestion by Meyer (1961, in Beumont, 1977) that clinical differences existed between anorexia nervosa patients who lost weight by restricting food intake and those in whom vomiting was a major symptom. They divided anorexics into two groups, "dieters" and "vomiters and purgers Although both groups showed concern about their weight, "dieters" were found to be more obsessional, intense, introverted and socially withdrawn, whereas "vomiters and purgers" appeared to have better social and sexual interactions than "dieters", were more extroverted and histrionic and likely to have had a premorbid history of obesity (Beumont et al, 1976).

At the same time however, Boskind-Lodahl (1976) and Boskind-Lodahl and White (1978) reported a group of patients who were within the low-normal weight range who evidenced the symptoms of binge-eating and purging and the psychopathology of anorexia nervosa. These researchers thus contended that eating disorders could be represented on a continuum, with anorexia nervosa at one end, binge-eating at the other, and "bulimarexia" (the name given to their syndrome) in the middle (Boskind-Lodahl and White, 1978).

Such studies appear to have sparked off interest in the constellation of binge-eating and purging symptoms and their presence in not only anorexia nervosa, but in individuals who were not anorexic (Russell, 1979; Johnson and Larson, 1982;

Nogami and Yabana, 1977; Stangler and Printz, 1980; Halmi et al, 1981; Wardle and Beinart, 1981; Pyle et al, 1981; Crisp, 1981; Palmer, 1979).

In this respect, Russell (1979), describing these symptoms as "an ominous variant of anorexia nervosa", laid down criteria for what he termed "bulimia nervosa" (Table 2). Although he thought it premature to consider bulimia a distinct syndrome, he acknowledged the tendency of patients with "bulimia nervosa" to be heavier, more socially outgoing and more likely to menstruate regularly. Interestingly, his group were characterised by various premorbid histories: a premorbid history of anorexia nervosa; what he termed a "cryptic" form of anorexia; and no premorbid history of anorexia.

Palmer (1979) called attention to the fact that many of the patients he reviewed either no longer met the weight loss criterion for anorexia nervosa (25 % loss of original body weight) as they had gained weight subsequent to an anorexic episode, or had merely been of abnormally low weight premorbidly, but not anorexic. He too suggested criteria for the binge/purge/vomit behaviour which he called the "dietary chaos syndrome" (Table 2) and concluded that it need not necessarily be part of the progression of anorexia nervosa. He concluded that the syndrome could best be understood as representing an intermediate position between anorexia nervosa (with binge-eating and vomiting) and obesity (where individuals engage in impulsive overeating).

In 1980, the DSM - III (APA, 1980) categorically differentiated anorexia nervosa and bulimia as distinct disorders, while still including binge-eating, vomiting and purging episodes as an associated feature of anorexia nervosa (Tables 1 and 2).

In one of the first detailed reports since the differentiation, Pyle et al (1981) suggested that bulimia as a syndrome can exist as a significant chronic disorder NOT associated with anorexia nervosa. They suggested that although patients may exhibit many of the symptoms seen in anorexia nervosa, they may never have had the marked weight loss (25 %) required for a DSM - III diagnosis of anorexia nervosa.

TABLE 2

DIAGNOSTIC CRITERIA FOR BULIMIC SYNDROME

Russell (1979)	Palmer (1979)	DSM-III (1980)	Russell (1985)
bulimia nervosa	dietary chaos syndrome	bulimia	bulimia nervosa
1. The patients suffer from powerful and intractable urges to over-eat. 2. They seek to avoid the "fattening" effects of food by inducing vomiting or abusing purgatives or both; 3. They have a morbid fear of becoming fat.	1. A grossly disordered pattern of eating in which some or all of the following behaviour occurs: self-induced vomiting, periods of abstinence from food for a day or more, excessive consumption of purgative medication following eating, bulimia, markedly idiosyncratic choice of food without swallowing, secret eating and eating confined to special circumstances, such as when driving a car at speed. 2. A preoccupation with food and eating, and sometimes with weight, which largely overrides other thoughts at least when the subject is alone. The impulse to eat is experienced as out of control, and its management is viewed as the key to well-being. Considerable thought and effort may go into attempts to control the impulse but they are usually unsuccessful and failure is followed by guilt, and emotional instability may parallel the dietary disturbance. 3. Body weight may change over a few kilograms in hours or days in response to the balance of input and output, but the range of weight is within or above normal limits for the subject's age, sex and height. Amenorrhea may or may not be present.	A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours). B. At least three of the following: (1) consumption of high-caloric, easily ingested food during a binge; (2) inconspicuous eating during a binge; (3) termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting; (4) repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics; (5) frequent weight flunctuations greater than ten pounds, due to alternating binges and fasts. C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily. D. Depressed mood and self-deprecating thoughts following eating binges. E. The bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.	1. Preoccupation with food associated with episodes of gross overeating. 2. Devices aimed at counteracting the "fattening" effects of the food ingested: especially self-induced vomiting or purging or alternation with periods of starvation. 3. The psychopathology of anorexia nervosa: fatness is so dreadful as to be avoided at all costs. 4. In "true" bulimia nervosa there is a history of a previous episode of anorexia nervosa, possibly of minor severity. However, other forms of bulimic disorder may arise de novo.

This finding has been supported by many other researchers (Fairburn, 1980; Mitchell et al, 1981; Crisp, 1981; Rost et al, 1982; Harris, 1983; Vandereycken and Pierloot, 1983; Johnson and Larson, 1982; Johnson and Berndt, 1983; Fairburn and Cooper, 1984). Some have also found that bulimics may not even have a premorbid history of obesity. (Thompson and Schwartz, 1982; Hawkins and Clement, 1982). ("Obesity" has not been defined by the various researchers).

In a recent examination of patients by Abraham and Beumont (1982), the symptoms of binge-eating, vomiting and purging were found to occur in association with the following:

(i) in association with anorexia nervosa, thus providing support for those who argue for the heterogeneity of anorexia nervosa as a syndrome and who regard bulimic symptoms as a distinct subgroup of anorexia nervosa (Beumont et al, 1976; Beumont, 1977; Crisp et al, 1980; Strober, 1981; Garfinkel et al, 1980; Garfinkel, 1981; Halmi, 1983); a complication or variant of anorexia nervosa (Bruch, 1973; Russell, 1979); or an associated behaviour (Feighner et al, 1972).

While several of the above researchers believe these symptoms to be associated with a more chronic course of eating difficulties, occuring after a long period of severely restricted dieting behaviour, others (Abraham and Beumont, 1982; Fairburn and Cooper, 1984) suggest that these symptoms cannot merely be considered as a manifestation of chronicity in anorexia nervo as these symptoms often antedate emaciation. In fact, Crisp (1981) suggests that individuals evidencing these symptoms of "the abnormal normal weight control syndrome" may go on to develop anorexia nervosa or even become obese.

(ii) in individuals of approximately (sub)normal to above average weight, with or without a premorbid history of anorexia nervosa or obesity. This finding has been supported by the work of Russell (1979); Fairburn (1982);

(1983); Vandereycken and Pierloot (1983); and Lacey (1984).

(iii) in overweight or obese individuals. This finding has been supported by the work of Halmi et al (1981) and Fairburn and Cooper (1984).

(These latter two groups qualify for a DSM - III diagnosis of bulimia).

Thus it seems clear that the symptoms of binge-eating, vomiting, laxative abuse and attempts at restrictive diets, occur within all weight-range groups and may be part of various conditions (Harris, 1983; Lacey, 1984). In fact, Vandereycken and Pierloot (1983) have suggested a continuum model of eating disorders, with restricter anorexics at one end, extreme obesity at the other end and bulimia (which they equate with Russell's "bulimia nervosa") occupying a pivotal place between these. They also suggest that individuals may move positions on the continuum.

Researchers within the field have thus tended not to distinguish between bulimics on the basis of weight and have tended to accommodate their symptoms either via a diagnosis of anorexia nervosa using Feighner et al's modified criteria (1972), as Garfinkel et al (1980) for example, or via a diagnosis of "bulimia nervosa" using Russell's (1979) criteria (as the diagnosis of anorexia nervosa and "bulimia nervosa" do not appear to be mutually exclusive). The diagnostic criteria of the DSM - III syndrome, bulimia, however stipulate that bulimia cannot be diagnosed if the diagnostic criteria of anorexia nervosa are also fulfilled.

The DSM - III criteria for a diagnosis of bulimia appear to have been widely accepted, particularly in the epidemiological research (Hawkins and Clement, 1980; Halmi et al, 1981; Pyle et al, 1983; Pope et al, 1984; Katzman and Wolchik, 1984). The only objections that appear to have been raised are those by Abraham and Beumont (1982) whose detailed study into "How patients describe bulimia or binge-eating" provides evidence for valid criticism of both Russell's (1979) criteria and the narrowness of the criteria

as laid down by the DSM - III for the diagnosis of bulimia. With regard to the DSM - III criteria, their research indicates that:

(i) episodes of binge-eating often last longer than two hours;

(ii) mood states after a binge vary;

(iii) the consumption of food is not always rapid;

(iv) the behaviour is not always secretive; and

(v) the food consumed does not only consist of high caloric foods.

It is also possible however to criticize the broadness of DSM - III criteria in that compensatory behaviours such as vomiting and laxative abuse are not required for a diagnosis of bulimia to be made. This implies that individuals who qualify for a DSM - III diagnosis of bulimia may represent a heterogenous population, ranging from those who only binge-eat to those who binge-eat and engage in one or more of the compensatory behaviours.

Although more recently Russell (1985) has amended his criteria for "bulimia nervosa" (Table 2), Fairburn and Cooper's (1984) findings highlight a problem with these modified criteria. Russell has suggested that "in true bulimia nervosa there is a previous episode of anorexia nervosa, possibly of minor severity", (1985, p 631). Yet, in Fairburn and Cooper's earlier (1984) study of subjects with "probable bulimia nervosa", few clinical differences were found between those with a premorbid history of anorexia nervosa and those without. This leads one to conclude that there appears to be no justification for excluding patients <u>without</u> a history of anorexia nervosa from the diagnostic categories of either bulimia or "bulimia nervosa" as Russell (1985) has suggested. Russell however appears to include individuals without a history of anorexia nervosa in his statement that "other forms of bulimic disorder may arise de novo", (1985, p 631). This leads one to conclude that bulimia may well arise in individuals without a premorbid eating disorder.

Due to the narrowness of Russell's (1985) criteria for "bulimia nervosa", which exclude all but those individuals with a premorbid history of anorexia nervosa, it was felt that for the purposes of this thesis the DSM - III criteria (APA, 1980) for bulimia should be adopted. While one is aware that this potentially allows a very heterogenous set of people to be included in the research, it is felt that there is no real justification for excluding individuals suffering from bulimia who have no premorbid history of anorexia nervosa other than to satisfy Russell's (1985) criteria.

1.3 CLINICAL FEATURES

Since Russell's (1979) description of the psychiatric and behavioural aspects of "bulimia nervosa" as well as its physical complications, several researchers have described the clinical features of bulimic patients largely supporting Russell's earlier findings (Pyle et al, 1981; Herzog, 1982; Abraham and Beumont, 1982; Fairburn, 1983). Only recently however have descriptions been provided using standardized recruitment and assessment procedures (Fairburn and Cooper, 1984).

1.3.1 Demographic data

Cooper (in press) suggests that two clear findings have emerged from studies on the distribution of the disorder, namely, that bulimia appears to be almost entirely confined to women and that these women are mainly young adults (the most common age ranging from 18 - 24 years), (Pyle et al, 1981; Johnson and Larson, 1982; Herzog, 1982) rather than adolescents, as is the case in anorexia nervosa (most common age ranging from 14 - 17 years).

A review of epidemiological studies reveals a prevalence of bulimia of 1 to 2 % in the general population (Fairburn and Cooper, 1982). Surveys

however, conducted among college populations (a population often chosen for research since bulimics presenting for treatment tend to be in late adolescence or early adulthood), reveal that the prevalence of bulimia varies from 3,8 % (Stangler and Printz, 1980) and 4,1 % (Pyle et al, 1981) to a staggering 13 % (Halmi et al, 1981, using the biggest sample yet).

Researchers have suggested that bulimics are likely to be Caucasian females from the middle to upper social classes. (Fairburn and Cooper, 1984; Pyle et al, 1981; Herzog, 1982; Johnson and Larson, 1982). More bulimics appear to have had heterosexual experience than anorexics, 20 to 25 % have been married and of these, many are divorced or unsatisfactorily married (Fairburn and Cooper, 1984; Pyle et al, 1981; Russell, 1979).

While it is not yet clear whether bulimia is prevalent in particular sub-groups of the population as has been found to be the case with anorexia nervosa, Garner and Garfinkel (1980) suggest that individuals who focus increased emphasis on a thin body shape (such as dancers and models) are at risk for developing anorexia nervosa and related dieting problems. It is thus hypothesized that an increased prevalence of bulimia may also be found in occupations placing a premium on body/weight control.

1.3.2 Onset

The disorder appears to be precipitated by a voluntary decision to diet in response to a traumatic event, such as a loss or separation from significant figures; by sexual conflicts, such as the beginning or termination of a relationship; by change in occupation or residence, resulting in feelings of insecurity; or by others' comments about their weight (Abraham and Beumont, 1982; Casper et al, 1980; Crisp, 1981; Pyle et al, 1981; Wardle and Beinart, 1981; Lacey, 1984). Weiss and Ebert (1983) however found no evidence that stressful life changes produced or maintained bulimia.

On average, bulimics presenting for treatment have evidenced the symptoms of bulimia for 2 to 5 years prior to presentation and approximately 12 to 19 months after the onset of dieting (Fairburn and Cooper, 1984; Johnson and Larson, 1982; Pyle et al, 1981; Stangler and Printz, 1980). It is often perceived to be a chronic illness due to the average duration of symptoms being in excess of 6 years (Herzog, 1982).

1.3.3 Binge-eating

The main complaint of patients with bulimia is that of a distressing loss of control over eating which occurs episodically. Such episodes appear to be subjectively clearly differentiated from overeating and are experienced as excessive, unpleasant and outside voluntary control (Cooper, in press). The amount, type and nutritional content of food consumed during a binge appears to vary widely both within and between individuals, and frequency of bingeing episodes is also variable both within and between individuals, varying from hours to weeks (Abraham and Beumont, 1982). On average, bingeing episodes are reported to occur at least daily however (Fairburn and Cooper, 1984), usually taking place during the day, after school or work, and at weekends (Pyle et al, 1981).

Bulimics appear to admit to strong appetites which they have difficulty controlling, and they report having difficulty eating regular meals. The typical eating pattern appears to consist of rigid dieting practices when the urge to binge is strongly resisted, interspersed with episodes of bingeing, which is experienced as a loss of control.

Clinical reports suggest that circumstances likely to precipitate binge episodes include internal feelings (dysphoric mood states, tension, boredom or hunger) as well as actual events (drinking alcohol, returning home from work/school or returning to the parental home; even eating). However,

Cooper (in press) suggests that further research is necessary for a detailed understanding of the psychological processes underlying these events which lead to loss of control.

Many bulimics appear to binge-eat in secret. They usually consume food which is considered "forbidden" and which they do not allow themselves to eat as a rule, but this is often entirely dependent on what is available (if bingeing at home) or what can be bought with the money available to them (if bingeing at other venues) (Abraham and Beumont, 1982).

Mostly binges are planned and food tends to be eaten quickly with little or no enjoyment, the binge lasting from 15 minutes to 8 hours, although 1 hour seems to be the average time period of a binge (Pyle et al, 1981).

Reasons given for ending a binge appear to vary from feelings of exhaustion and the desire for sleep to abdominal pain, or the presence of others forcing the bulimic to continue with normal activities (Abraham and Beumont, 1982).

After a binge, patients frequently report experiencing feelings of depression as well as suicidal ideation, guilt and self-disgust. Abraham and Beumont (1982), however, suggest that the post-binge mood appears to be influenced by a patient's ability to induce vomiting, as individuals who do not induce vomiting appear to report the occurrence of negative moods more often than those who vomit.

1.3.4 Weight history

Speculation that bulimia is a chronic complication of anorexia nervosa abounds and Adamson (1984) suggests that this is due to the later mean age of presentation, and to Russell's initial findings that 68 % of his patients had a history of true or "cryptic" anorexia nervosa. This has however been found to be true

only in a minority of cases (Johnson and Larson, 1982; Fairburn and Cooper, 1984; Pyle et al, 1981; Katzman and Wolchik, 1984) and many bulimics have in fact previously been overweight (Abraham and Beumont, 1982; Halmi et al, 1981) or obese (Fairburn and Cooper, 1984).

At presentation, the majority of patients appear to be of normal body weight or are within the normal range for their peer group, although marked weight fluctuations are common (Abraham and Beumont, 1982; Pyle et al, 1981; Cooper, in press).

Fairburn (1983) suggests that the bulimics' values regarding body and weight resemble those found in patients with anorexia nervosa. They seem to be extremely sensitive to changes in weight and shape and exhibit a profound fear of becoming fat, often weighing themselves frequently (Fairburn and Cooper, 1984). Few however pursue weight loss to the same degree as those with anorexia nervosa, and Cooper (in press) suggests that the desired weight of these patients is no different from that of women of equivalent age in the general population, although several researchers have found these patients' ideal weights to be lower than the minimum weights suggested by Insurance Tables (Pyle et al, 1981; Russell, 1979; Weiss and Ebert, 1983).

1.3.5 Weight control methods

The most common method of weight control appears to be self-induced vomiting. After bingeing, bulimics may attempt to rid themselves of the food consumed by inducing vomiting (Fairburn, 1983) and subjective feelings of distress are experienced if they are prevented from doing so. Some patients also report vomiting during a binge-episode in order to make room for more food (Abraham and Beumont, 1982). Vomiting is generally accomplished by inducing the gag reflex using fingers while others learn to vomit spontaneously

(Chiodo and Latimer, 1983). Vomiting episodes appear to last from 5 to 30 minutes depending on the ease of vomiting and the quantity, and as they generally occur in secret, are thus often undetected (Abraham and Beumont, 1982).

Laxative abuse also occurs in an effort to control weight. Purgatives are usually taken after a binge in quantities far in excess of the recommended dosage but may also be taken at other times in lesser quantities (Abraham and Beumont, 1982; Fairburn, 1983). A minority of patients also use other drugs to control their weight (appetite suppressants, diuretics), or exercise and attempt "fasting" as additional means of controlling their weight. Abraham and Beumont's (1982) findings suggest that patients increase the number and severity of forms of behaviour aimed at weight loss as the duration of their eating problem increases.

1.3.6 Physical complications

Patients with bulimia are at risk for serious physical complications. (Neuman and Halvorson, 1983; Fairburn, 1983; Cooper, in press). Common problems appear to be chronic indigestion, facial oedema, swollen salivary glands, bloodshot eyes, irregular menstrual periods, sore throats and erosion of dental enamel. Dry, sensitive skin and fatigue may also occur while somatic complaints are common: headache, dizziness, chest and back pains (Weiss and Ebert, 1983).

Overloading the stomach may result in overexpansion and stomach rupture. Laxative abuse may result in colon damage and the inability to evacuate naturally. Of special concern are the fluid and electrolyte abnormalities resulting from vomiting and purgative abuse, especially potassium loss, and the subsequent hypokalaemia which may lead to cardiac arrhythmias, renal damage, tetany, epileptic seizures and dehydration (Fairburn, 1983).

1.3.7 Associated psychiatric features

Patients with bulimia often evidence a high level of non-specific psychological disturbance (Cooper, in press) although anxiety and depression most commonly dominate the clinical picture (Fairburn, 1983; Fairburn and Cooper, 1984; Herzog, 1982; Russell, 1979; Pyle et al, 1981; Johnson and Larson, 1982; Katzman and Wolchik, 1984). Anxiety (situational, social and panic attacks) is often experienced in relation to food and eating (Cooper, in press). Depressive symptoms are most likely to be secondary to the eating disorder (Cooper, in press) and dysphoria and fluctuations of mood according to the bulimics' eating pattern have been documented (Johnson and Larson, 1982; Weiss and Ebert, 1983). These patients when distressed have also been found to be high suicide risks (Russell, 1979; Garfinkel et al, 1980; Weiss and Ebert, 1983), a problem thought to be related to their poor impulse control (Weiss and Ebert, 1983; Pyle et al, 1981).

Patients also describe themselves as being preoccupied with thoughts of food and eating (Fairburn, 1983) which often impairs social and occupational functioning (Johnson and Larson, 1982; Pyle et al, 1981).

Body image misperception has also been found to be present in some bulimics (Fairburn, 1983; Boskind-Lodahl, 1976; Boskind-Lodahl and White, 1978; Katzman and Wolchik, 1984).

Current data suggests that several personality and behavioural deficits appear to coexist in bulimics, although it is difficult to generalize about their personality traits (Fairburn, 1983). Lacey (1984) however attempted to divide bulimics into two groups: a neurotic group (75 %) and a personality disordered group (18 %). The neurotic group appeared to be hard-working, ambitious and they exhibited high ethical standards. A superficial impression

was that they were resourceful and coping but in reality they were found to experience low self-esteem and feared failure, especially in relationships. The personality disordered group were found to be substance abusers who often stole food or money to support their food "habit".

Other researchers have suggested the following features as descriptive of the bulimic's personality and behaviour: low-self-esteem (Weiss and Ebert, 1983; Katzman and Wolchik, 1984; Boskind-Lodahl and White, 1978); emotional instability and histrionicity (Weiss and Ebert, 1983; Crisp, 1980; Pyle et al, 1981); poor sexual adjustment (Weiss and Ebert, 1983; Mitchell et al, 1981; Dunn and Ondercin, 1981). Rost et al (1982) suggested that although bulimics aspire to a masculine self-ideal (characterized by traits of independence, ambition, dominance) their behaviour in both sexual and other relationships is characterized by impulsivity, passivity, dependence on others' approval, lack of assertion and inability to express anger. They appear to view men as superior, do not communicate their sexual needs and exhibit a high external locus of control so that they often feel controlled by others, helpless and inadequate (Herzog, 1982).
Despite these deficits, these individuals often exhibit surface adjustment, maintaining adequate school and work performance. Garfinkel and Garner (1982), however, suggest that the serious nature of their disturbed identity is often hidden by "superficial identifications with others and their responding to the expectation demands of parents and peers" (p 55).

1.4 AETIOLOGY

A discussion of the aetiology of bulimia is deemed to be important in order to place the role of certain family characteristics and dynamics in context, as it seems likely that bulimia, like anorexia nervosa, is a complex disorder with an interplay of factors involved in its development. As yet however, bulimia is a disorder

of unclear aetiology, since it has only recently been recognised as separate from anorexia nervosa (and by only some researchers!). As a result, any explanation of aetiology remains hypothetical and is presented as such.

Various theorists have attempted to understand and explain eating disorders. A combination of various theoretical models, most notably family and psychodynamically oriented, will be employed in the discussion on aetiological factors. However, this does not purport to be a complete review of the state of knowledge in this area.

This discussion will attempt to specify factors which have been considered as predisposing to, precipitating, and maintaining of, the syndrome of bulimia. However, the literature often does not distinguish between factors associated with bulimia and those associated with anorexia nervosa, so that some overlap may occur in this discussion.

1.4.1 Predisposing factors

It has been postulated that in the families of both anorexics and bulimics, disturbed interactional patterns and family structure produce circumstances which are likely to prohibit maturation in the child, so that she is ill-prepared to cope with the demands of adulthood and experiences difficulty separating and individuating (Rampling, 1978; Adamson, 1984; Bemis, 1978). Parents appear routinely to subvert the individual needs of the child to their sense of what is appropriate. Thus, the child may not learn to rely on her own inner feelings, bodily and/or emotional cues, may lack autonomy and experience guilt if she seeks to have her own needs met (Rampling, 1978; Bruch, 1973; Palazzoli, 1974).

This situation is thought to lead to permanent defects in the ego structure, a blurred personal identity, low self-esteem, feelings of inadequacy, lack

of inner control and marked dependency on others (Adamson, 1984; Johnson and Larson, 1982), and the development of a child who is compliant and yielding with high expectations of self, masking a strong need for approval (Casper et al, 1980; Nogami and Yabana, 1977; Russell, 1979; Katzman and Wolchik, 1984; Dunn and Ondercin, 1981).

The biological demands of puberty, rapidly succeeded in adolescence by the social requirement of forming heterosexual relationships, place the adolescent in a dilemma, since social demands, family mores, and biological drives all clamour for allegiance (Rampling, 1978). If, however, the maturational tasks of adolescence are or have been covertly blocked by the family pathology, then control of one's own body may be the only arena for establishing a sense of autonomy (Crisp, 1981).

1.4.2 Precipitating factors

Adolescence, developmentally, is a period of change and vulnerability, and the prospect of sexuality is likely to be accompanied by fears of the emergence of unacceptable and/or uncontrollable emotions. If the traumatic events or stressful life situations for which the individual does not have adequate coping skills occur at the same time however, this may give rise to intolerable anxiety (Rampling, 1978). In individuals predisposed to the development of an eating disorder, eating, dieting, bingeing and purging may well become imbued with the potential for being the means by which unacceptable or uncontrollable desires or appetites other than hunger are satisfied or rejected. In order to gain some control over self, the body may become the focus of control.

The methods employed to gain control over body form are legion.

Bulimics because of their predisposition to obesity (Bemis, 1978; Fairburn and Cooper, 1982; 1984) and stronger appetites, may however need to exercise a particularly high degree of restraint over their food intake in order to achieve an acceptable weight (Cooper, in press).
This makes them more likely to turn to methods other than simple dieting to attain weight loss (Adamson, 1984). Intermittent reinforcement for weight reduction, at least in the early stages of the disorder, may well be provided by the cultural premium on slimness and the social stigma attached to being overweight (Neuman and Halvorson, 1984; Bemis, 1978).

Dietary restraint may however lead to physiological deprivation as a result of nutritional deficiency, experienced as "food craving/preoccupation" (Slade, 1982, p 174). The bulimic may resort to bingeing to satisfy her intensified appetite, and purging in an attempt to find some alternative method of weight control that does not involve the negative effects of self-starvation (Slade, 1982).

Furthermore, her lack of effective coping with stressful and anxiety producing situations (Chiodo, in press), her difficulty in asserting herself, inhibition of anger and her predisposition to affective disturbance (Fairburn and Cooper, 1984; Cooper, in press; Pyle et al, 1981; Dunn and Ondercin, 1981) may make her more likely to turn to food to assuage these dysphoric mood states (Johnson and Larson, 1982) and to purging in an attempt to undo the effects of bingeing, as she is highly sensitive to excessive body weight (Chiodo, in press).

1.4.3 Maintaining factors

Although the individual admits to the negative consequences of her behaviour, such as shame and guilt, she may continue to engage in this behaviour as it allows her to avoid weight gain, to obtain relief from negative affect and to allay guilt and anxiety related to sexual conflicts (Chiodo, in press). In addition, increased time spent on the binge / purge / vomit cycle may serve as the perfect excuse to remain isolated, thus avoiding/restricting social and interpersonal contact and possible heterosexual involvement (Boskind-Lodahl and White, 1978).

Impulsive desires to eat large quantities of food appear to be dreaded, because to succumb is equated with loss of control which engenders guilt and remorse. Hence purging/vomiting is reinforced in an attempt to re-establish a sense of control. The negative feelings resulting from purging may however lead to renewed despair and hopelessness and this, in addition to the inability to restrict her appetite, sets up the circumstances for the next binge, with the excessive concern for food as the hub (Adamson, 1984).

The behaviour appears to be further reinforced by the fact that any attempt at change gives rise to intolerable anxiety which then plunges the individual again into the only method she knows to allay anxiety - eating ; and the cycle begins again.

1.5 MANAGEMENT

As has been previously mentioned, bulimia has only recently been established

as a separate clinical entity and its treatment is not nearly so well defined as that of anorexia nervosa (Neuman and Halvorson, 1984) although Fairburn (1983) has suggested that the condition is difficult to treat and it is not yet known whether any intervention affects long term outcome.

Several authors have recommended that inpatient care may be valuable if there is a risk of suicide or if eating habits prove refractory to outpatient care (Crisp, 1981; Neuman and Halvorson, 1984). They suggest that hospitalization may provide containment, break the binge/starve/purge/vomit cycle, and result in the development of appropriate eating habits with body weight goals matched to the population mean weight/height norms (even though this may mean placing the patient on a diet to induce weight loss). As an adjunct, the use of anti-depressants is suggested in the treatment of depressive symptoms, while the patient is hospitalized. The long term use of medication remains controversial however, especially if the patient is not hospitalized. Because of the bulimic's poor impulse control, the risk of overdosing is high (Herzog, 1982).

Lacey (1984) suggests that the underlying psychopathology needs to be examined in order to help the bulimic find new ways of coping, and suggests that a combination of therapies in the therapeutic milieu, such as individual psychotherapy, group and family therapy may be useful. Once the patient has gained temporary respite from her impulsivity, or even without previous hospitalizition, outpatient group therapy is recommended by Crisp (1981) who suggests that these patients may respond to peer-sharing of psychosexual and social problems and benefit from the mutual support.

A new approach which is receiving much acclaim is a cognitive - behavioural approach, conducted on an outpatient basis for approximately 4 months (Fairburn and Cooper, 1984).

It should be noted that not all these facilities are useful for every patient. Herzog (1982) suggests that the treatment be individualized as response to treatment is likely to depend on

(i) aetiological and clinical factors;

(ii) an ability to look at intrapsychic conflicts underlying behaviour;

(iii) degree of motivation for treatment (Lacey, 1984).

1.6 PROGNOSIS

The diagnosis of bulimia, as a separate syndrome, or as symptomatic of anorexia nervosa, appears to have important implications for treatment (Herzog, 1982).

Several researchers have found episodic bingeing and purging / vomiting to be a poor prognostic factor in anorexia nervosa (Russell, 1979; Garfinkel et al, 1980). Since these symptoms are central to the diagnosis of bulimia, this may account for the reason why bulimia is said to have a poor prognosis, especially if there is a premorbid history of anorexia nervosa(Crisp, 1981).

No satisfactory outcome or follow-up studies comparing anorexics with bulimics have been reported however (Halmi, 1983).

It must be borne in mind though that normal weight bulimics premorbidly often have good social and occupational functioning, extroverted natures (as opposed to the more introverted anorexic) and no previous psychiatric treatment, factors which are often cited as good prognostic indicators in outcome studies of eating disorders (Halmi, 1983).

1.7 COMMENT

In summary, it appears that the research into bulimia has been beset with problems relating to the controversy surrounding the conceptualisation of bulimia as a distinct clinical entity versus bulimia as a subgroup within anorexia nervosa,and the lack of clarity with regard to various terms used. In order to clarify issues and avoid confusion, in this thesis the following terms will be employed:

The term bulimia will be used to denote the DSM-III (1980) diagnostic category and syndrome, the individual being known as bulimic.

The terms bingeing, binge or binge-eating will refer to a bout of uncontrolled and excessive eating - (symptom).

The term purging will be used to refer to the attempts of the patient to lose weight via use of purgatives.

The term starve will be used to denote the severely restrictive diet employed by the individual after binges in an attempt to induce loss of weight.

Individuals who satisfy the various diagnostic criteria for a diagnosis of

anorexia nervosa will be known as <u>anorexics</u> and may be subdivided into <u>anorexics with bulimic features</u> and <u>restricter anorexics</u>.

The term <u>anorexic with bulimic features</u> will be used to describe those anorexics who also exhibit the symptoms of bingeing/purging/vomiting.

The term <u>restricter anorexic</u> will be used to describe those anorexics who do not exhibit episodes of binge-eating.

Because various diagnostic criteria have been employed in the research into bulimia, findings are often not comparable; yet assumptions about the clinical features of bulimia, its aetiology, management and prognosis are made by many researchers who generalize from the results on anorexic patients to construct a picture of the bulimic - not a particularly scientific approach!

This also appears to have been the case with regard to family issues, where research on the families of anorexics has often been generalized to describe the families of bulimics, while little or no research appears to have been conducted into the families of individuals suffering from bulimia, rather than anorexia nervosa. It is thus suggested that these families be investigated before generalizations are made.

This thesis will attempt to explore the families of bulimics in order to come to some understanding of the way in which these families function, and their possible role in the aetiology of the disorder.

In the following chapter, family issues relating to eating disorders, particularly anorexia nervosa, will be detailed as it seems possible that individuals qualifying for a diagnosis of bulimia will have been included

in this research. The systems approach to eating disorders and anorexia nervosa in particular will be outlined in order to provide detailed data against which the findings in this study can be assessed.

The methodology employed in this study into the family functioning of bulimics from a systems perspective will be detailed in Chapter Three.

In Chapter Four, both quantitative and qualitative results from the present study will be presented.

In the final chapter, Chapter Five, these results will be discussed and the formulation of a hypothetical model of family functioning proposed. Some comparison of these families and the families of anorexics, and an overall evaluation of this study, will also be presented.

It is hoped that some understanding of the families of bulimics will not only add to the limited knowledge at present available on bulimia, but also be of use in delineating areas for therapeutic input for the family therapist.

CHAPTER TWO

FAMILY ISSUES IN THE PATHOGENESIS OF EATING DISORDERS

2.1 Introduction 29

2.2 Overview 30

2.3 Demographics and family values 34

2.4 Family psychiatric history 39

2.4.1 Genetic factors 39

2.4.2 Other psychiatric illnesses 39

2.5 Dyadic relationships 43

2.5.1 The marital dyad 45

2.5.1.1 Family atmosphere 47

2.5.2 Parent-child relationship 48

2.5.2.1 Mother-daughter relationship 48

2.5.2.2 Father-daughter relationship 49

2.5.3 Limitations of the dyadic approach 50

2.6 The systems approach 51

2.6.1 Overview 51

2.6.2 Family systems perspectives 52

2.6.2.1 Palazzoli 53

2.6.2.1.1 Communication 53

2.6.2.1.2 Leadership and blame-shifting 54

2.6.2.1.3 Coalitions 54

2.6.2.2 Minuchin 55

2.6.2.2.1 Enmeshment 56

2.6.2.2.2 Overprotectiveness 56

2.6.2.2.3 Rigidity 57

2.6.2.2.4 Conflict 57

2.6.2.3 Crisp 58

2.6.2.4 Criticism of family perspectives 59

2.6.2.5 Norris and Jones 62

2.6.2.5.1 The family myth 63

2.6.2.5.2 The enmeshed dyad 64

2.6.2.5.3 The processing barrier within the patient 64

2.6.3 Psychometric assessment of families 65

2.7 Comment 68

CHAPTER TWO

FAMILY ISSUES IN THE PATHOGENESIS OF EATING DISORDERS

2.1 INTRODUCTION

Research on the families of bulimics appears to be limited to the demographic aspects of these families, family history data in search of genetic variables, or parent-child relationships. However, there appears to be little or no information available on the whole family system of the bulimic. As previously mentioned, it seems possible that research into the families of anorexics may have included the families of bulimics, in view of the problems associated with the conceptualization of bulimia as a syndrome distinct from anorexia nervosa. Thus it seems of importance to review not only the research available on the families of bulimics but also that available on the families of anorexics.

This chapter will therefore deal mainly with the research into the families of anorexics, although the available research on the families of bulimics will also be reviewed. Although the main focus of this thesis is the phenomena of family systems, research into family issues ar various levels will be considered in order to put the role of the family system into perspective.

Problems regarding the direct application of the systems formulations on the families of anorexics to the families of bulimics are also presented, and the necessity for this present study is discussed.

2.2 OVERVIEW

Factors residing in family systems have long been implicated in the pathogenesis of anorexia nervosa. In fact, the earliest reports of anorexia nervosa recognised that families interacted with patients in ways believed to be detrimental to the patient (Gull, 1868 and Lasègue, 1873, cited in Garfinkel and Garner, 1982; Yager, 1982).

While 19th century physicians recognised a familial role in the disorder,this was not explored. Instead, they postulated the existence of "unspecified psychological causes", while exploring and treating the physical symptoms (Minuchin et al, 1978, p 12).

In the 20th century however, under the influence of psychiatry and particularly of Freud, many investigators began a shift of concern from the somatic manifestations of the disorder to a concern for underlying psychological issues. The role of the family was still largely ignored however, as under the influence of the early psychodynamic theorists the study of anorexia nervosa became the search for a specific psychodynamic of the illness.

In the 1960's Hilde Bruch, one of the foremost investigators of anorexia nervosa, began calling for a more comprehensive approach which could encompass the contextual components of anorexia nervosa, which many investigators independently were beginning to acknowledge. Yet, still the ongoing interactions of patient and family were outside the focus and instead the dyadic, pathological interactions between the mother and child (mainly in the past) remained the focus of attention.

In the 1970's however, many investigators began to recognise the interrelationship between the individual and her social context (Minuchin et al, 1978). This

meant that many psychiatric illnesses, anorexia nervosa included, began to be described according to a systems approach - an approach which attempts to explain the anorexic syndrome not only by looking at specific family factors such as marital conflict, absent parent, losses and separations, or the behaviour of one specific family member, but also in terms of the interrelationship of all family members.

The very fact that several theories have been propagated on the role of the family in the pathogenesis of anorexia nervosa means that this syndrome as well as that of bulimia is currently being investigated and treated at virtually every level of "biopsychosocial organization" (Yager, 1982, p 43).

While the main focus of this thesis is the phenomena of family systems, it is acknowledged that these syndromes are probably the product of multiple interacting forces within the individual, the family and culture (Garfinkel and Garner, 1982). In order to put the role of the family system into perspective however, research into family issues at various levels will be considered.

This chapter will therefore deal with research relating to the following issues:

(i) a description of the demographic and cultural aspects of these families;
(ii) the possibility of a genetic basis for anorexia nervosa and bulimia in these families;
(iii) associated psychiatric manifestations in these families;
(iv) charateristics of parents;
(v) parent-child interactions; and finally
(vi) phenomena of whole family systems.

Before these issues are reviewed however, it is important to stress a number of methodological problems and deficiences relating to these investigations

and results:

(i) Studies attempting to isolate pathogenic family issues have been retrospective and are contaminated by the fact that having an anorexic child brings about significant changes in both familial and marital relationships (Garfinkel and Garner, 1982), so that phenomena which predispose to the illness are often indistinguishable from those that are secondary elaborations of symptoms. Factors operating prior to, or at the onset of, the disease, or during the active phase of illness, may in fact differ significantly from those which may occur later and there is no reason to suppose that forces operating at each stage are equally distributed or the same. For example, Crisp et al (1974) found that the parents of anorexics did not display marked psychopathology prior to their daughters' weight restoration. However, they did develop increased psychopathology following their daughters' improvement.

(ii) There have been few studies with appropriate control of significant variables in control groups.

(iii) There has often been no measurement or quantification of relevant variables being examined so that clinical descriptions abound and retrospective distortion in family members and observer-bias in researchers contaminate the data which results in the perpetuation of myths about the illness (Yager, 1982).

(iv) Given the significant differences that have been described between anorexics with bulimic features, restricter anorexics and bulimics, it is possible that marked familial differences between these groups exist. However, much of the research in this area has tended to regard these groups as homogenous and it may be that when the various groups have been combined differences have been obscured, resulting in

significant differences being overlooked.

(v) Descriptions of families are often based on relatively small numbers, with findings generalized as if they could describe the whole group, forgetting that as with most clinical problems, there are few, if any universal patterns (Yager, 1982). In fact, many researchers have suggested that the range of family psychopathology is wide and may not even be specific to anorexia nervosa (Crisp et al, 1974; Kalucy et al, 1977; Sours, 1980; Bliss and Branch, 1960; Dally and Gomez, 1979).

(vi) Differences in sample selection, diagnostic criteria and socioeconomic status make if difficult to compare different series of patients and their families reported in the literature. For example, Yager (1982) suggests that Minuchin et als' (1978) study is biased in that only intact families with predominantly younger patients have been studied, whereas a considerable number of families of anorexics and bulimics are broken, either through divorce or death, often before the onset of symptoms (Kay and Leigh, 1954; Nogami and Yabana, 1977).

Yager (1982) in fact suggests that broken families must be investigated before comprehensive formulations can be achieved, since families do not cease to function as families merely because one member is absent. With syndromes as complicated and diverse as those of anorexia nervosa and bulimia, it is possible that symptoms are multidetermined, or at least multi-influenced, so that various family factors are implicated in the pathogenesis and maintenance thereof. No one explanation will adequately suffice.

2.3 DEMOGRAPHICS AND FAMILY VALUES

Since families cannot be considered in isolation from their cultural context, at a macroscopic level social class factors will no doubt be important in developing an understanding of anorexia nervosa and bulimia as they to some extent reflect values, attitudes and patterns of child-rearing in these families. A very common finding has been that both anorexia nervosa and bulimia are overrepresented in upper middleclass and upper class families (Crisp, 1970; Crisp et al, 1976; Bruch, 1973; Hall, 1978; Morgan and Russell, 1975; Herzog, 1982; Johnson et al, 1983).

Explanations for this phenomenon have been as follows:

(i) that there may, in fact be a greater prevalence of these disorders in these specific social classes (Kalucy et al, 1977);

(ii) that there is a greater willingness or capacity to detect illness or seek psychiatric help in upper classes;

(iii) that lower social class status protects individuals from the illness (Crisp, 1970). It has been suggested that lower social class adolescents are often in a position to consolidate social roles earlier than higher classes since less unrealistic and ambitious demands are imposed on them. Bruch (1973) in fact posits that the high achievement orientation of anorexic families may have much to do with the selection factor. The parents, for example, are described by Sours (1980) as placing higher intellectual demands on their children so that academic achievement takes precedence over socio-emotional experiences.

(iv) Crisp (1970) postulates that the higher social classes may be more susceptible to the value of slimness or the lower classes more tolerant of obesity. This view is supported by Sours' (1980) description of the higher socio-economic groups as being more diet-conscious and concerned with the external physical appearance. He states that aesthetic reasons thus provide the motive for carbohydrate avoidance in many women, fatness being frowned upon socially, especially by the media, and being associated with sloppiness, unattractiveness, depression and lack of self-discipline.

Other studies however show that the families of anorexics are from all classes (Rowland, 1970; Kay and Leigh, 1954). While these inconsistences may be related to differences in diagnostic criteria, there are several researchers of the opinion that as anorexia nervosa has become more common it appears to be more equally distributed through all social classes (Garfinkel and Garner, 1982; Dally, 1969).

Theander's (1970) interpretation of this more equal distribution is that with better medical care for the lower social classes there is better detection, but it seems highly likely that factors in our culture which predispose to eating disorders such as attitudes about body weight, achievement and self-control are becoming more evenly distributed throughout society.

Families fulfill a variety of needs for individuals, including affectional and instrumental needs, as well as being the first link between the individual and his culture. Garfinkel and Garner (1982) pose the question whether particular families magnify aspects of a culture and whether this may be a predisposition to the illness, for it seems possible that some families will be more vulnerable than others to pressures for slimness, perfection and performance in the cultural climate.

While there have been no controlled studies examining these issues, accumulated anecdotal reports have repeatedly stressed certain family characteristics. These appear to include particular family values, cultural groups, weight and eating problems, emphasis on external appearance and youth, and increased reliance on external standards for regulating self-worth, as well as actual physical characteristics.

With regard to family values, Palazzoli's (1974) findings, based on interviews conducted with the anorexic and her parents, were that the families of anorexics hold to agricultural - patriarchal values, roles, rules and taboos despite living in an urban industrial setting.

According to the patriarchal code, the family has to be both powerful and stable. This calls for a strict division of labour with husband and wife occupying instrumental and affective roles respectively and there is the tendency in the family to resist change, both from within and without.

The family ethos is described as one of self-sacrifice: the more self-denial an action demands, the more praiseworthy it must be. Hence the antithesis, self-indulgence, is considered reprehensible. The collective sense of the family appears to override individual development and there is the tendency to foster togetherness, so that no-one is excluded. Everyone experiences the joy or sadness of everyone else.

However, the value of such a description cannot be adequately assessed, as Palazzoli herself admits that her findings are exploratory, and whether this is a necessary or permissive condition for the development of anorexia nervosa, or whether it is applicable to an understanding of bulimia, is not yet clear.

Although researchers have also attempted to isolate particular cultural groups as being high-risk groups for the development of these disorders, because

of the values espoused, no firm evidence is yet available although the disorders appear to be more common in subcultures where food, eating and family solidarity, especially around the table, is prevalent (Sours, 1980).

"Weight pathology" has also been studied in both the families of anorexics (Halmi et al, 1977; Kalucy et al, 1977; Garfinkel et al, 1980; Strober, 1981) and those of bulimics (Pyle et al, 1981) and a variety of "pathology" reported: overweight and underweight parents, weight fluctuations and dieting in parents, and obesity (particularly in the families of bulimics). Yager (1982), however, notes that few of these studies include appropriate general population comparison groups so that the significance of the prevalence of overweight and underweight individuals cannot be adequately evaluated.

A further contribution for explaining specificity for anorexia nervosa is offered by Kalucy et al (1977) who suggest that excessive concerns about eating, body shape and weight can become the vehicle for family interaction, coping or communication. Within these families, food preoccupation may emphasize orality and dependency and may be used to defend against aggressive, sexual and autonomous strivings. Nevertheless, such "deviant" attitudes are common among many contemporary families <u>without</u> an anorexic or bulimic individual and as these researchers point out, abnormalities surrounding eating are not shared by <u>all</u> families with eating disordered individuals (Yager, 1982).

A preoccupation with external appearances also appears to be in evidence in these families. Anecdotal reports suggest a preoccupation in these families with physical exercise to the point where activity and self-control are overvalued (Kalucy et al, 1977). Bruch (1973), on the basis of her interviews with families noted that fathers in particular are preoccupied with physical appearance, proper behaviour and performance,

both in themselves and their children; traits which although of importance in western society, appear to be more pronounced in the families of anorexics.

Nevertheless, preoccupation with external appearances may occur in many narcissistic individuals who are not eating disordered and in their families, and it is highly unlikely that this preoccupation is the perogative of families of eating disordered individuals.

The physical characteristics of families with eating disordered individuals have also been investigated in an attempt to discover particular families and individuals at risk in the population. These include family size and birth order (Hall, 1978; Bruch, 1973; Rowland, 1970; Theander, 1970; Halmi et al, 1977; Pyle et al, 1981); the preponderance of particular gender siblings (Theander, 1970); age of parents (Bruch, 1973; Halmi et al, 1977; Dally, 1969; Hall, 1978; Theander, 1970); and loss of parent though divorce or death (Bruch, 1973; Halmi et al, 1977; Pyle et al, 1981; Nogami and Yabana, 1977; Herzog, 1982). Results have however been inconclusive, due to the methodological problems associated with these studies.

While attempts abound to test empirically psychological theories which postulate specific family variables as playing an influential role in the development of eating disorders, several researchers are of the opinion that the family variables of importance may in fact exist at a genetic level. Evidence for the existence of some genetic vulnerability is examined in the following section.

2.4 FAMILY PSYCHIATRIC HISTORY

2.4.1 Genetic Factors

There appear to be no clearcut genetic factors, for even though anorexia nervosa in both mother and child has been reported (Halmi et al, 1977; Hall, 1978), this is uncommon (Theander, 1970). However, several studies have reported a 3 to 15 % occurence of a history of anorexia nervosa or marked low weight in parents (Kalucy et al, 1977; Morgan and Russell, 1975; Halmi et al, 1977; Beumont et al, 1978; Crisp et al, 1980) while other studies reveal an overrepresentation of sibling cases (Theander, 1970; Dally and Gomez, 1979; Halmi et al, 1977; Garfinkel et al, 1980).

Although there have also been a number of reports of anorexia nervosa in both monozygotic and dizygotic twins since the 1940's (Garfinkel and Garner, 1982), studies fail to provide conclusive evidence, due to methodological problems.

Such findings cannot however be simplistically attributed to genetic causes and further research is necessary to tease out possible genetic from psychogenic contributions.

2.4.2 Other Psychiatric Illnesses

While no clearcut findings are available with regard to genetic vulnerability, several researchers have attempted to uncover familial predispositions to other psychiatric disorders in order to uncover whether eating disorders are linked to other psychopathologies and how these may be transmitted.

It has also been suggested that individuals growing up in families where some psychiatric disorder is prevalent may well be at risk for the development of psychiatric disorder themselves, through psychiatric factors at play or familial predisposition, and many researchers have attempted to uncover the psychopathology of families of eating disordered individuals.

Increased but non-specific psychopathology within the parents of anorexics has been identified by several researchers (Crisp, 1970; Crisp et al, 1974; Morgan and Russell, 1975), with a greater incidence of general health problems and psychiatric disorder occuring in the parents of anorexics with bulimic features as opposed to those of restricter anorexics.

A variety of physical illnesses often associated with stress, the so-called psychosomatic disorders, such as gastro-intestinal disorder and migraine, have been noted in the parents and relatives of anorexics (Halmi et al, 1977; Kalucy et al, 1977). This raises the issue of whether these families are more prone to psychosomatic disorders. Systems theorists such as Minuchin and Palazzoli, have in fact called anorexia nervosa a psychosomatic disorder and developed formulations to explain the occurence thereof. While these will be elaborated on at a later stage, the question still remains as to whether bulimia can be classified as a psychosomatic disorder and whether family factors in operation are genetic or psychogenic.

Many studies have also reported emotional disturbances in large numbers of the parents of bulimics and anorexics, (although Theander (1970) reports that emotional illness appears in the same proportion as in the general population), but precise descriptions differ. Emotional disturbances noted have been anxiety neurosis (Kay and Leigh, 1954), and phobias, depression and mania (Crisp et al, 1970; Morgan and Russell, 1975; Kalucy et al, 1977). However,

the occurrence of these disorders, their relationships to eating disorders and their effect on families has not been delineated and so is open to interpretation.

Research also suggests a strong relationship between eating disorders and affective illnesses (Strober, 1981; Garfinkel et al, 1980; Strober et al, 1982). Hudson et al (1983) have put forward the following argument in favour of such a relationship:

(i) depressive symptoms are common in patients with anorexia nervosa (Morgan and Russell, 1975; Crisp et al, 1980) as well as in bulimic patients (Nogami and Yabana, 1977; Pyle et al, 1981; Hudson et al, 1982);

(ii) outcome studies have indicated that anorexics often exhibit depressive symptoms at follow-up (Morgan and Russell, 1975; Hsu et al, 1980; Crisp, 1980);

(iii) biological tests have suggested a link between eating disorders and affective disorders (Hudson et al, 1982);

(iv) reports reveal that both anorexics and bulimics have responded favourably to psychotropic agents used in the treatment of affective disorders (Pope and Hudson, 1982 cited in Hudson et al, 1983; Rivinus et al, 1984);

(v) family studies have found a higher than expected prevalence of affective disorder in the relatives of anorexics and bulimics (Winokur et al, 1980; Pyle et al, 1981; Hudson et al, 1983; Rivinus et al, 1984).

However, despite the growing evidence of an association between anorexia nervosa and bulimia and familial risk for affective and related disorders,

how this association operates is unknown. Cause and effect statements cannot be made and whether this predisposition operates via genetic or environmental pathways is as yet unknown.

Alcohol abuse in these families has also been investigated in view of the suggestion by several authors that bulimia may represent an impulse disturbance. Excessive use of alcohol in parents of both anorexics and bulimics, especially fathers, is reported by several authors (Kalucy et al, 1977; Hall, 1978; Beumont et al, 1976; Garfinkel et al, 1980; Strober, 1981; Strober et al, 1982; Pyle et al, 1981) varying from 12 to 20% . It is not always clear however, to what extent alcohol excess is a problem in its own right prior to the onset of the eating disorder; whether alcohol is used as a coping mechanism in these families; or whether it is even used to self-medicate primary affective disorders. Thus while a strong association between bulimic features and familial risk for impulse disturbance is suggested, the role of the family is still not clear.

The parents of bulimics and anorexics are likely to serve as role models for personality traits and behaviours in their children. In an attempt to investigate personality development in these individuals and to understand their behaviour, the personalities of parents have also been investigated. Investigations have however revealed no uniform patterns (Dally, 1969) although "typical" personalities are still alluded to.

Nevertheless, the following traits have been observed in these parents and appear to be of relevance in view of the personality features often associated with anorexic and bulimic individuals: obsessionality as a marked personality trait in both fathers and mothers (Kalucy et al, 1977), and rigidity and compulsivity in fathers (Bemis, 1978).

Marked differences however seem to exist between the parents of restricter anorexics and anorexics with bulimics features (Strober et al, 1982): fathers of anorexics with bulimic features tend to exhibit more signs indicative of personality disorder - hostility, immaturity, impulsiveness and dyscontrol, whereas fathers of restricter anorexics appear to be characterized by greater reserve and passivity. Likewise, mothers of anorexics with bulimic features exhibit more pronounced depression and emotional dissatisfaction with intrafamilial relations and appear to be less socially introverted, submissive and tense when compared with the mothers of restricter anorexics. When anorexics' parents are compared with controls however, mothers do not differ significantly from controls, although fathers still display higher degrees of conscientiousness. (Garfinkel et al, 1983).

It seems evident that while many of these factors may be involved in the pathogenesis of anorexia nervosa and bulimia, these factors cannot be considered sufficient and necessary for the development of these syndromes, since other factors, such as the dyadic relationships within the family and the interaction of the family as a whole, will undoubtedly influence the development of these syndromes. It is thus to these aspects that attention will now be turned.

2.5 DYADIC RELATIONSHIPS

With the recognition in the late 1960's and early 1970's of the importance of the interaction between family members as well as constitutional factors within the child herself, several theorists and researchers began focusing attention on dyadic relationships within the families of individuals with eating disorders. Some workers observed disturbed mother-daugter relationships, others described pathology within the father-daughter dyad, while others suggested conflict within the marital dyad as an important contributory factor to the emergence of anorexia nervosa in the child (Bruch, 1973; Palazzoli, 1974; Kalucy et al, 1977).

The psycho-analytic schools, in particular, studied the psychodynamics of the individual patient, relating these illnesses to early mother-child relationship disturbances with subsequent oral regression (Ehrensing and Weitzman, 1970; Bruch, 1973; Thöma, 1967; Wold, 1973; Palazzoli, 1972).

These retrospective reconstructions of the early mother-child relationship emphasize excessive symbiosis and ambivalent maternal control. Central to this model is the concept of a mother who rewards compliance to her wishes, is overprotective and does not permit separation in the child (Palazzoli, 1974); a mother who needs to have a submissive perfect child as her own fulfillment (Sours, 1974); and a mother who superimposes on the child her own concept of the child's needs (Bruch, 1973), so that the child has difficulty achieving autonomy.

Rampling (1980), however, suggests that it would be naive to stress a simple linear causality between abnormal mothering and the subsequent development of anorexia nervosa or bulimia, since succumbing to the negative aspects of the primary bond obviously depends on reciprocal influences between parent and child created by identification processes in the child and projective processes within the mother.

Thus although these formulations are empirically useful in the understanding and treatment of patients, their validity relies on retrospective accounts by patients and families, and the frequency with which mothers describe the patients' early years as asymptomatic and trouble free (Sours, 1974; Rampling, 1980) bears witness to the obstacles inherent in the postulation of generic theories.

It should also be remembered that these illnesses have not always been found to be related to major earlier problems in the parent-child relationship (Crisp, 1970). Neither can causal relationships be described, since by the

time the family presents for treatment, the child's relationship with the parents may have changed dramatically as a result of the family's grappling with the patient's emaciation, or as a result of the bulimic's often secretive lifestyle. Thus premorbid relationships may be obscured.

In the late 1960's however, a psychodynamic theorist, Mara Palazzoli, began exploring the various dyadic relationships within the family, through a series of conjoint interviews with mother, father and anorexic, in an attempt to understand the individual within the context of her family. Her work (in Anthony and Koupernik, 1970, pp 319 - 331) and related research for which her work served as impetus, can be seen as the forerunners of the systems approach to families and is discussed below.

2.5.1 The marital dyad

According to Palazzoli neither spouse has ever adequately separated from his/her family of origin. She suggests that the husband perceives his wife as the idealized oral mother, existing totally for the satisfaction of his needs, so that every time his wife's behaviour provides evidence of her being a "real" person, he feels abandoned and unfairly treated. Via sadistic communications, he begins to convey his aggressiveness due to the frustration of his deep fantasy needs.

Limited support for the concept of a "needy" husband comes from Wold (1973) who found that these men were raised by mothers who dominated their husbands, insisted on total obedience from their sons and exhibited low frustration-tolerance so that these men could not refuse her favours. It seems highly possible then that such a man would engage in an ambivalent relationship with his "idealized mother image" (Anthony and Koupernik, 1970, p 323). Palazzoli postulates that the wife's ambivalent relationship with her own mother is re-evoked because of her husband's needs. Wold (1973) describes the

mothers of these women as having been demanding, critical, possessive and controlling, and mothers of anorexic patients were observed to have been dominated and controlled by their own mothers for years. The harmful influence of the grandmothers with their dominating presence (real or fantasized) in the families of anorexic patients has also been suggested by Sperling (1965), cited by Palazzoli (1970).

Hence marriage for these mothers appears to have been perceived as a liberating experience, an opportunity to achieve social status and independence without their perceiving the "conflicting reality" in their partners (Anthony and Koupernik, 1970, p 324).

Palazzoli further suggests that these women have never been sexually responsive. Instead they evidence open or secret disgust with sexuality, often feeling used if excessive sexual demands are made of them. Sexual dissatisfaction and general marital disharmony has also been found by other researchers (Kalucy et al, 1977; Crisp et al, 1980). Strober (1981) in fact found significantly higher levels of disharmony reported by parents of anorexics with bulimic features, compared with the parents of restricter anorexics.

According to Palazzoli, such dysfunction is often couched in strongly expressed family attitudes towards sex, which is often not discussed. However, marital difficulties appear to remain unacknowledged and few negative feelings are expressed. Instead, it appears that compensations are attempted in non-sexual areas, such as domestically and occupationally.

Topics relating to affective issues appear to be avoided by tacit consent, conversations relate only to matter of fact subjects with no feelings conveyed, and there are few shows of affection (Groen and Feldman - Toledano, 1966).

Palazzoli suggests that a facade of "order at any cost" is erected. Parents appear utterly devoted to work and home, observing all the conventional social norms, acutely concerned with external appearances, with the discrepancy between love expressed and obsessive exemplary devotion to duty, right behaviour and overservitude most pronounced in the mother (Groen and Feldman-Toledano, 1966). Palazzoli in fact describes the mother as feigning acceptance of traditional behaviour patterns and merely pretending to submit to the father and to be devoted to the family. Behind the family facade however, there is a constant state of tension which produces moodiness, sulking and irritability with occasional bickering about trivia.

2.5.1.1 Family Atmosphere

It seems inevitable then that the family atmosphere will become progressively oppressive and ritualistic, possibly due to the need of the family to maintain the structure.

The hypothesis of a high investment in togetherness is supported by Heron and Leheup (1984) who found that anorexics were more likely to come from an exclusive family, with little conflict and few external stresses due to limited contact with the outside world and professed internal harmony.

Of the rituals deemed important in these families, feeding rites have often been cited as playing an important part. Crisp and Fransella (1972), for example, report that these families often construe one another in terms of size, weight and eating habits and that weight and eating behaviour form an important part of the family's dialogue and expression.
Palazzoli states that feeding is often a complicated dutiful undertaking for the mother and regular mealtimes are stressed as these are often a family time of togetherness, despite the underlying tense atmosphere. Various members

appear to follow different diets or have food fads and Kalucy et al (1977) state that often the parental equation, weight control = impulse control, is at play.

2.5.2 Parent-child relationships

2.5.2.1 Mother-daughter relationship

Palazzoli postulates that the unhappy wife soon seeks out a close relationship with her daughter - in fact the same relationship she had with her mother. This may possibly account for the wide range of relationships between mothers and daughters suggested by research findings (Kay and Leigh, 1954; Dally, 1969; Kalucy et al, 1977; Beumont et al, 1976; Morgan and Russell, 1975).

According to Palazzoli, the daughter becomes her mother's consolation. She also suggests that the daughter cannot not be good and compliant to her mother's expectations - in fact she is often overprotective toward the mother (although fathers are not excluded). An explanation for this is offered by Wold (1973) who suggests these mothers have learned to please people as a result of being unable to express anger toward their own mothers, and their attitude of dutiful mother and martyr evokes guilt in their children should they express any opposition. The concept of a "model child" is also propounded by Groen and Feldman-Toledano (1966) who go on to describe the child's excessively close relationship with her mother as a "continuation of /fixation in an infantile dependency", (p 672) often interpreted by the mother as a sign of normality. In addition they suggest that the child's attempts at establishing an identity are met with by parents', especially mothers' attempts to establish their own dominance via "better" and more logical arguments.

Thus the puberty struggle for independence takes place in an unemotional,

pseudo-rational climate in which parents' logical approach dominates while they appear unaware of the feelings of helplessness and protest this evokes in their children. Palazzoli suggests that overemphasis on intellectual development is in fact evident from the child's overachievement at school.

Palazzoli has also observed interesting patterns with other children in the family. These parents often distinguish sharply between sons and daughters - the male is generally more respected and less involved in the pathological parental needs, and if there is another daughter, the mother establishes an entirely different kind of relationship with her, what Palazzoli calls a "mutually highly erotic relationship" (Anthony and Koupernik, 1970, p 325) and she suggests that because the patient has highly ambivalent feelings toward her sister, she does not imitate her.

Palazzoli suggests that only in her illness does the anorexic express her despair, protest and desire to have her needs met. The concept of unmet needs is also suggested by Groen and Feldman-Toledano (1966) who found anorexia nervosa precipitated by a conflict situation which threatens the emotional security of the patient and for which she needs emotional support from parents, but which she does not receive . This appears to result in the patient's regression due to her inability to solve the problem.

2.5.2.2 <u>Father-daughter relationship</u>

While Yager (1982), in his theoretical review of family issues suggests that the whole gamut of father-daughter relationship are seen in these families, studies of the late sixties and early seventies appear only to describe the distant and/or antagonistic father and since there appears to be no evidence to prove otherwise, we are forced to consider the formulations at hand.

Palazzoli suggests that the father, who is already ambivalent toward and jealous of the children because of his own dependence on his wife, becomes more confused and irritated by the double-bind situation in which his wife places him. While she expresses her distress at his distance from the children, she persists in sharing only the daily mishaps concerning them, rather than allowing him to come to know them. Groen and Feldman-Toledano (1966), however, suggest that the fathers themselves play an active part in increasing their isolation, since they are often insignificant due to their engrossment in their professional roles.

Palazzoli suggests that while mother is the conspicuous figure, father is the emotional absentee, generally overshadowed or secretly or openly belittled by his wife who often undermines his authority. If the daughter attempts to approach the father, mother immediately interferes, suggesting either that father is too busy or explaning that she is the mediator. Wold (1973) even suggests that mother actively encourages a negative fantasy relationship between father and daughter by threatening the child with father's punishment when she opposes mother. The fact that fathers and daughters remain strangers merely serves to reinforce the fantastical nature of their relationship.

2.5.3 Limitations of the dyadic approach

While these formulations have increased our understanding of family interrelationships, current conflicts in the family although well observed and clearly described, are still presented as recurrences of conflict in the patients' and parents' early childhood,and the ongoing influence of current circumstances is often not focused on as the thrust of the investigation is still the search for intrapsychic factors. Most importantly, anorexia nervosa and bulimia are not the same syndromes, so that formulations on the anorexic patient and her relationship cannot automatically be seen to be describing the bulimic and her family relationships.

2.6 THE SYSTEMS APPROACH

2.6.1 Overview

During the 1970's, with increasing clinical experience it became apparent to researchers that it is not the one or other facet in the family constellation that accounts for healthy or abnormal development, but the dynamic interaction between all members of a family and the role they play in relation to each other. It seems that various researchers independently began to reformulate their ideas relating family structure to the anorexic syndrome (Kalucy et al, 1977; Crisp, 1980; Minuchin et al, 1978; Palazzoli, 1974; Morgan and Russell, 1975; Caille and Abrahamson, 1977; Norris and Jones, 1979). No longer was it considered sufficient to give a family history in biographical or anecdotal details as was done previously, but the essential aspects of the family transactions needed to be formulated as generalized or even abstract concepts which might serve as a basis of comparison between families, and which would also be applicable to different cultural and social settings. The multiple interactions in the family began to be seen as a "system". Instead of isolated behaviour traits of one or other parent, multiple functions of the family began to be clarified and emphasis shifted to the way the different members interact, as the importance of the repetitive patterns in basic learning experiences was recognized.

Within a systems perspective, the family is seen as "a laboratory for the social, psychological and biological development and maintenance of family members" (Epstein, Levin and Bishop, 1981, p 447), a self-regulating system with characteristic transactions, methods of communication and subsystems composed of the members aligned by age, role and other common qualities. Yager (1982) suggests that from this perspective the patient's symptoms are viewed as being evoked, supported and reinforced

by certain transactions in the system and playing a part in the family's entire psychological economy. In general it appears that family systems can be characterized by communication "rules", power structures, role flexibility, clarity and expressiveness of ideas and feelings, emotional involvement, security of each individual's boundaries, and by the efficacy of the family as a problem solving unit in accomplishing the dual tasks of helping individuals to have a sense of group belongingness, while at the same time developing autonomy.

Whereas in earlier studies, the locus of pathology was conceived to be in the individual, the result of inner contradictions and external forces which converge on the individual, within the systems model the individual is conceived to be an active participant in the process, in turn affecting the family (Bruch, 1973). Accordingly, the interdependence and circular interactions of forces is emphasized with the individual's behaviour simultaneously caused and causative (Garfinkel and Garner, 1982). Bruch (1973) has also suggested that approaching the problem from this wider perspective permits the recognition of "subtle patterns of disturbed interactions" (p 76) in various areas of family life, particularly in families such as these where disturbance is denied.

2.6.2 Family Systems Perspectives

Pioneering work in this field was done by Palazzoli (1974) and Minuchin et al (1978) with the families of anorexics. On the basis of their family interviews they concluded that certain family relationships are closely related to the development and maintenance of psychosomatic syndromes in children and that the illness in turn plays an important role in maintaining the family homeostasis by taking the focus off family problems and uniting parents in their joint concern for the patient (Aponte and Hoffman, 1973; Szyrinski, 1973; Anthony and Koupernik, 1970).

2.6.2.1 Palazzoli

Palazzoli and her colleagues developed an interest in the family of the anorexic through the work of Haley on communications in families of schizophrenics. Using Haley's model of communication in families as their theoretical framework, they conducted semi-structured interviews with the anorexic and her parents. Certain predominant characteristics emerged and these are described below (Palazzoli, 1974, pp 204 - 216):

2.6.2.1.1 Communication

(i) The family members generally communicate in a coherent manner, verbally as well as non-verbally. The exception is those families where the patient's symptoms are complicated by violent or aggressive behaviour toward other members of the family or by bulimic features: the members' non-verbal communication often contradicts verbal communication or is masked so that the intended message is obscured. In particular, anorexics with bulimic features display thought and communication disorders not present in restricter anorexics, particularly at times of bingeing and vomiting, and family observations suggest that this is related to a "complete breakdown of family communication" (p 205).

(ii) It is common for members to reject messages sent by others. Contradiction is common, especially with regard to the content and how the speaker has defined him or herself in the relationship. In families of anorexics with bulimic features, Palazzoli found a greater tendency for members to disqualify or even disconfirm the messages of others. This she labelled communication of the "psychotic type" (p205).

2.6.2.1.2 Leadership and Blame-shifting

Parents are described as being reluctant to assume responsibility for the leadership of the family so that they attribute their decisions to others. In this way the actions of family members are never attributed to personal preferences but to the needs of others and for their good. Thus when something does go wrong, no member is really prepared to assume responsibility. Palazzoli suggests that this "spirit of self-sacrifice" (p 213) is perceived by members as veiled threat, which evokes guilt and results in denial of any criticism and conflict.

2.6.2.1.3 Coalitions

According to Palazzoli, the system of alliances within these families is the most problematic aspect of these families. She believes that these alliances form the basis of implicit family rules which give rise to a whole series of distorted behaviour patterns. Palazzoli believes that these families have difficulty tolerating two person relationships both within and outside the family as these are perceived to be a threat to family solidarity, and any alliances that are formed are usually covert.

The failure of the marital relationship appears to generate the formation of cross generational alliances. The marital relationship appears to be characterized by a facade of unity which generally conceals a profound underlying disillusionment. Each partner is thought to compete with the other for moral superiority about who has made the greater sacrifices for the sake of the family. Mothers perceive themselves as being bountiful and generous, totally dedicated to the good of others, thus making them beyond reproach of overinvolvement. Fathers, too, see themselves as essentially good, decent, rational and well-balanced, their only fault being that they

"may have put up with too much for the sake of peace", as opposed to their wives whom they describe as "irrational" (p 213).

Palazzoli describes their relationship as one of "symmetry through sacrificial escalation" (p214). In it, superiority serves to prove that one has sacrificed more in the line of duty than the other, and allies are sought. These allies are however confined to family members so that the appearance of exemplary behaviour and marital unity is maintained in the outside world.

Palazzoli postulates that the parents place the patient in an untenable situation: she is invited by both parents to ally herself with each against the other as well as to make up for each parent's shortcomings. As a result the patient is at once both secret husband and wife and is called to divide herself equally between parents. She calls this situation "three way matrimony" (p 211) and notes that this results in the daughter's inability to build an independent identity or rebel openly on reaching adolescence.
It is suggested that the daughter accepts this role and often develops her symptoms precisely when the system is threatened by changes, from without or from within (for example, when the daughter changes or leaves school or when there is a change in the family system of alliances).

Palazzoli suggests that "in a system where every communication has so high a probability of being rejected, the rejection of food (by anorexics) seems to be in full keeping with the interactional style of the family. In particular it is in perfect tune with the sacrificial attitude of the group, in which suffering is the best move" (p 216).

2.6.2.2 <u>Minuchin</u>

Like Palazzoli, Minuchin et al (1978, pp 30 - 33) emphasize a series of

characteristics which they believe typify "psychosomatic families", describing the families of patients with juvenile onset diabetes mellitus, asthma and anorexia nervosa, where pathological family interactions appear to evoke and sustain the child's symptoms. With these hypotheses in mind, they conducted semi-structured interviews with the anorexic and her family and identified the following family characteristics:

2.6.2.2.1 Enmeshment

Family relationships are said to be characterised by interaction in which members are overinvolved with one another, each person may answer for any other and family members intrude on each other's thoughts and feelings. This is said to result in members developing poorly differentiated perceptions of one another and themselves.

Minuchin postulates that there is often a poorly delineated boundary between the nuclear family and the parents' families of origin. Excessive togetherness and sharing, loyalty and protection take precedence over autonomy and self-realization so that the anorexic learns to subordinate herself to others' needs.

2.6.2.2.2 Overprotectiveness

These families appear to be unduly concerned with each other's welfare. Parental concern for, and preoccupation with, the child's behaviour is apparently expressed in hypervigilance of the child's movements and psychobiological needs, so that the child develops a vigilance over her own actions and an obsessive concern for perfection. The result is the child's increased dependency on parental approval and loyalty to family values, and retardation of autonomy, competence and involvement outside the home. Because parental control is maintained under the guise of concern, the child

cannot protest. Members are thought to make their wishes known indirectly and unselfishly so that disagreements and initiative are viewed as betrayal. The denial of self and differences for another's benefit appear similar to Palazzoli's description of the family spirit of self-sacrifice.

2.6.2.2.3 Rigidity

This is expressed as the need to maintain appearances, the status quo and conventional social roles. In periods of change, such as the child's entrance into adolescence, when orientation to peers is necessary above orientation to family, these families experience great difficulty in relinquishing their accustomed patterns of behaviour. In addition, extrafamilial stress may require adaptations that the family cannot make and these may precipitate the illness. They postulate that the anorexic resolves the adolescent crisis of individuation by attempting to remain forever a child, and her overinvolvement in an inflexible family system maintains this.

2.6.2.2.4 Conflict

There is a tendency to avoid overt conflict within the family, with consequent lack of conflict resolution. Harmony is highly valued and the family's threshold for conflict is low, a point also emphasized by Palazzoli.

The child's involvement in parental conflict is considered to be a key factor in the development and maintenance of psychosomatic symptoms. In an effort to deal with family tension, the child may be forced into alternative siding with one parent against the other, sometimes more permanently with one parent. This they call "triangulation" (p 33).

In "detouring", (p 33) the parents suppress their own conflicts by focusing

on the sick child as the only family problem. The child thus becomes an "avoidance circuit" helping to diffuse the conflict, and since this common concern serves both parents well the child's symptoms are rewarded and sustained, becoming embedded in the family organization.

2.6.2.3 Crisp

Crisp (1980, pp 66 ff) has also postulated that anorexia nervosa is more likely to develop in families that prohibit adolescent maturation (or at least fail to prepare the patient to cope with adolescence). In these families with "neurotic constellations" the child's symptoms are viewed as protecting one or both parents. He postulates that these family constellations provide the climate in which these symptoms develop, although he suggests that the illness appears to be precipitated by a wide variety of events which threaten family homeostasis.

From his case studies he suggests the following prevalent themes:

(i) the developing child challenges the identity of the parents and their mutual relationship;

(ii) the adolescent's potential emancipation may provoke maternal anxiety and the daughter's regression may be protective and serve to allay the mother's fears;

(iii) the family is a "pseudofamily"(with parents living separate lives) that threatens to break up once the children grow up;

(iv) the adolescent is given the task of living out either or both parents' ideals or fantasies;

(v) the adolescent feels guilty or remorseful for hurting someone in the family by her independent behaviour;

(vi) anorexia nervosa provides a way to diminish the ambivalent contest of wills between patient and parent about who is better at adult roles: the patient withdraws from the competition;

(vii) the adolescent models on a parent who has had an eating/weight problem and which resurfaces at the daughter's adolescence.

2.6.2.4 Criticism of Family Perspectives

While these systems formulations provide valuable insight into the families of anorexics, the following problems raise serious questions about their applicability to the families of bulimics.

Minuchin et al (1978) have suggested that the families of anorexics are "psychosomatic" families and states that " the psychosomatic element is apparent in the transformation of emotional conflicts into somatic symptoms" which "may crystallize into a severe and debilitating illness like anorexia nervosa" (p 29).

While Minuchin may view anorexia nervosa as a psychosomatic disorder, it is unclear to what extent bulimia may be viewed in this light. Although bulimia may result in the long term in physical problems, the major problem of the bulimic appears to be bingeing and purging, rather than refusal of food which results in severe emaciation in anorexics. Bulimics in fact often maintain their disorder and an apparently "normal" way of life without much change in their external appearance, in comparison with anorexics whose external appearance undergoes marked change.

If one, however, speaks of emotional conflicts which are expressed via some physical illness, it is possible that bulimia could be described as a psychosomatic illness. Nowhere however, do Minuchin et al (1978) lay down criteria by which an illness may be judged psychosomatic or not, and for this reason, one cannot assume that the family functioning described for anorexics is applicable to that of the families of bulimics, unless proven so.

Minuchin et al (1978) have also suggested that the anorexic child and her symptoms form an avoidance circuit for the parents' marital conflicts and that symptoms are thus rewarded and sustained. In the case of the bulimic individual however, her symptoms are often unknown to her family so that parents do not have a sick child on whom to focus, instead of focusing on their own conflict. Thus the bulimic and her symptoms cannot be interpreted as as avoidance circuit in her family, at least not in the manner suggested by this formulation.

Minuchin et al (1978) also explain the anorexic's development of her symptoms as an attempt to remain a child. It is not clear to what extent this statement can be applied to the bulimic, for many of these individuals develop their symptoms once they have left home and many do "mature" occupationally and socially, although some immaturity at an emotional level has been postulated.

It is possible that the symptoms of the bulimic may be serving an alternative function within her family, but this function needs further investigation as this formulation does not appear to provide an adequate explanation of how these symptoms may be maintained in the bulimic, often long after she has left her family.

While Palazzoli's (1974) characteristics of the families of anorexics may well apply to the families of bulimics, this systems formulation was developed by observing the families of anorexics and thus would require

validation on the families of bulimics.

Her formulation also presents problems in its direct application to an understanding of the bulimic and her symptoms. Palazzoli (1974) suggests that the anorexic's rejection of food is symbolic of the interactional style of communication in the family, a style where communications are rejected.

While this may well describe the bulimic's rejection of food, once she has eaten it, how does one account for her bingeing behaviour via this model? Palazzoli does not answer this question, but one could postulate that perhaps an alternative style of communication is in operation in the families of bulimics. This hypothesis however requires testing before any clearcut statements can be made.

Palazzoli's (1974) description of how anorexic symptoms are maintained in the family are unlikely to apply to the bulimic. Palazzoli (1974) suggests that the anorexic's symptoms are maintained as they comply with the family's "spirit of self-sacrifice", that is, the anorexic's symptoms receive reinforcement from the family because she appears to be suffering, a concept which is highly valued in these families. Bulimics are however seldom seen to be suffering by their families, hence their symptoms cannot be rewarded and maintained in the same manner. Thus the question of how the bulimic's symptoms are maintained is not addressed by this formulation.

While Crisp's (1980) "themes" appear to be an attempt to overcome the "universal" model of explanation for anorexia nervosa (Minuchin et al, 1978; Palazzoli, 1974), as Yager (1982) points out, many of these themes are the universal problems of troubled families with their adolescent children, so why anorexia nervosa? In addition, Crisp's (1980) constellations are not

descriptions of overall family functioning, so we remain uncertain as to how these families function.

Finally, as has already been mentioned in connection with all of these formulations, they were developed by observations and descriptions of the families of anorexics, and further research will be needed in order to validate these characteristics as those of the families of bulimics.

2.6.2.5 Norris and Jones

Criticism of these systems theorists also comes from two South African researchers, Norris and Jones (1979), who in fact developed an alternative hypothetical systems model to describe the families of anorexics. Their model appears to be of some significance as they break with traditional systems-oriented family theorists, who too often, they suggest, regard the problems of the index patient as the outcome solely of family systems pathology, whereas the reasons why one family member rather than another becomes symptomatic are not clear, nor why that member develops his particular symptoms rather than others.

They feel that too often the index patient is regarded as the "weakest link" (p 108) in the chain of family interaction because of factors such as genetic predisposition or chance situation. They contend instead that syndrome - specific symptoms emerge only as the joint outcome of equilibrating processes within the family as a whole and specific oppositional forces within the individual, who is a subsystem, an active contributor, rather than victim.

Thus while acknowledging the valuable contribution of other systems theorists to the understanding of family processes, Norris and Jones' (1979) assessment is that these models do not take cognisance of processes within the individual

or of dyadic relationships.

They attempt to address this problem by stressing an analysis of processes within the individual, within dyads and within the family system in order to come to an understanding of family functioning.

They propose a model which takes the standpoint of anorexia nervosa as a "distortion" (p 109) at the system - subsystem (family - individual) interface, and that by means of this distortion the forces of the conflicting processes are held in equilibrium.

On the basis of their family interviews and individual interviews with the anorexic they identified three primary pathological processes at work in the family (pp 109 - 110):

(i) the bonding family myth;

(ii) a pathological enmeshed dyad, with either parent, which is seen as a necessary property for the emergence of anorexia nervosa; and

(iii) a processing barrier within the patient.

2.6.2.5.1 The Family Myth:

Norris and Jones (1979) use the term "myth" to describe the "set of values, expectations and attitudes a family has of itself which determines rules and modes of behaviour and expression for the family, irrespective of their practical value or the nature of situations in which a family may find itself. All transactions within the family and all input and output between the family and its immediate environment are monitored and regulated by this myth so that genuine, self-inspired interactions among family members are severely restricted." (p 109).

Norris and Jones describe the family's values, expectations and attitudes as revolving around closeness, harmony and unity with everyone subjugating themselves to the family's prescribed roles. There is a denial of aggression, but if and when aggression does erupt, it is immediately suppressed or dissipated so that conflict is nor perceived, let alone resolved. In addition, achievement which enhances status is valued. As a result, the family maintains a good social image and peace at all costs, internally as well as externally. Reinforcing this myth is the idealised image of the central nurturant mother-figure. She dominates as she is invested with the task of upholding the myth-fulfilling rules and sanctions.

2.6.2.5.2 The Enmeshed Dyad

An overly close affiliation between one parent and child is formed long before the onset of the illness. Such a closely involved familial dyad with its "diffused and competitive role positions" and "oscillating affect" (p 109), challenges the unity of the family and threatens to divide the family into two camps. However, while the enmeshed dyad appears to support the family myth with its own internal love, harmony and co-operation, all bodes well.

2.6.2.5.3 The Processing Barrier within the Patient

Strivings for individuality and independence in every sphere come to the fore in adolescene. However, the adolescent trapped in the family myth and enmeshing dyad, experiences great difficulty in fulfilling her "biologically determined drives". (p 110)

One solution is to deny the existence of her own individual needs by idealising the demands of the family myth and her dependency on the enmeshing parent.

Norris and Jones suggest that even the anorexic's competitive behaviour is perceived by her as a co-operative act in which she is living up to the idealised mother-image.

In this way they suggest that the anorexic, by becoming ill, achieves a compromise solution for the conflicting forces. She propagates the myth and holds the family closer in their concern for her; she reinforces the dyad by providing it with a legitimate excuse for overinvolvenent, her illness, and a realistic reason for maintaining her dependent position. At the same time she asserts her power and independence via food/body issues. Norris and Jones (1979) suggest that there is maintenance of the symptom and reluctance to change because of the powerful position experienced by the anorexic and because she is the outlet for the family's suppressed aggression and has defused family conflicts.

While it is again clear that the maintenance of these symptoms cannot readily be seen to describe the maintenance of bulimic symptoms, this model appears to provide a more comprehensive framework than the other approaches for describing the disorder. The family functioning of bulimics still however needs to be investigated, in order to assess the similarity or difference in functioning between the families of bulimics and those of anorexics.

2.6.3 Psychometric Assessment of Families

Several studies using psychometric techniques have investigated the families of anorexics in an attempt to test the hypotheses generated by family theorists.

Support for the concepts of a family myth and the enmeshed dyad (Norris and Jones, 1979); family alliances (Palazzoli, 1974) and overprotectiveness

(Minuchin et al, 1978) was provided by Kalucy et al's (1977) findings on the families of anorexics. They found that closeness, loyalty and mutual interdependence is highly valued; that an excessively close or negative relationship occurs between the anorexic and one or both parents; and that where a symbiotic relationship occurs, this leads to oedipal alliances which act as a barrier to normal adolescent development.

Garfinkel et al (1983) have also attempted to provide quantitative data on the families of anorexics. Using a family assessment measure very similar to the one which will be employed in this study, Skinner et al's (1983) Family Assessment Measure (FAM), these researchers attempted to measure areas of family functioning which have been cited as being of relevance in the families of anorexics, such as achievement expectations, control and dealing with affect. Significant findings were revealed: mothers and daughters were similar in rating increased difficulties in Task Accomplishment (the family's problem-solving skills, its ability to identify tasks and solve them, and its ability to respond to a crisis); Role Performance (family members' understanding of what is expected of them, their willingness to assume the assigned roles, and their ability to adapt to new roles as is required); Communication (the degree of mutual understanding among family members); and Affective Expression (the content, intensity and timing of feelings).

Fathers however, did not report any familial problems, suggesting marked differences in the perception of difficulties in these families or their willingness to be reported by different members.

Garfinkel et al (1983) have however noted that these difficulties may not be specific to the families of anorexics as many of the families of patients with other psychiatric disorders have been found to display difficulties on these dimensions.

Nevertheless, this study does appear to provide some support for Palazzoli's (1974) suggestion of disturbances in these families' communication and difficulties with dealing with problems and roles appropriately (leadership and blame-shifting).

While this study provides no information on the families of bulimics, it nevertheless provides valuable data for comparison purposes.

Strober (1981) has also provided quantitative data of some importance on the families of anorexics, as the families of anorexics with bulimic features appear to differ from the families of restricter anorexics. On the Moos Family Environment Scale (FES) the families of anorexics with bulimic features were characterized by significantly higher levels of conflictual interactions and expressions of negativity among members, while the families of restricter anorexics were more strongly associated with greater cohesiveness (mutual support and concern among family members) and organization (clarity of structure and rules and division of responsibility).

Significant differences also appeared to exist with regard to emotional relationships with parents: anorexics with bulimic features appeared to be more distant and alienated from both father and mother than restricter anorexics.

While no comparisons appear to exist with regard to the family environment of bulimics, Weiss and Ebert (1983) in their examination of bulimics' relationships with their parents, found that they evidenced higher scores on negative attitudes toward parents than controls.

2.7 COMMENT

From the review of the family literature it seems clear that even within the description of the families of anorexics differences have been observed with regard to the families of anorexics with bulimic features and the families of restricter anorexics.

It seems likely then that if there are differences between these families, the families of bulimics may well differ from those of anorexics, so that the family functioning in the families of anorexics cannot be readily applied to the family functioning of bulimics, at least not without further research.

While the influence of many family variables, both genetic and psychogenic, is acknowledged, the conceptual model adopted in this thesis will be a systems perspective and an understanding of the family functioning of bulimics will be espoused from this perspective. Exploratory data, both quantitative and qualitative, will be presented.

The following issues should be borne in mind however, in order to place this exploratory study in context:

(i) Just as it is not yet clear what characterises the family that invites anorexia nervosa as opposed to other disorders, so it is unlikely that clearcut answers will be forthcoming on the family that invites bulimia;

(ii) Just as no necessary family preconditions for promoting the appearance of anorexia nervosa in a vulnerable person have been distinguished from those that are simply permissive but nonessential, it is unlikely that firm answers will be attained in the case of bulimia;

(iii) While preliminary data is available on the family factors conducive to maintaining the anorexic syndrome, it is suggested that the findings provided by this study should be regarded as exploratory data, which will serve as an impetus for further research in this area.

In the following chapter, the methodology employed in this study will be presented.

In Chapter Four, both the quantitative and qualitative results are discussed and a hypothetical model of family functioning in the families of bulimics is presented.

In Chapter Five, the final chapter, a possible explanation for the development and maintenance of bulimia from a systems perspective is given. The family functioning of the families of bulimics is also compared with the family functioning of the families of anorexics, as described by systems theorists. In addition various theoretical issues are raised with regard to the diagnoses of bulimia and anorexia nervosa, and the strengths and limitations of this study are discussed.

CHAPTER THREE

METHODOLOGY

3.1 Introduction 71

3.2 Methodological issues 71

3.2.1 Retrospective method 71

3.2.2 Interview and self-report questionnaire 74

3.3 Subjects 78

3.4 Measures 84

3.4.1 The McMaster Model of Family Functioning 84

3.4.1.1 Description 85

3.4.1.1.1 Problem solving 87

3.4.1.1.2 Communication 88

3.4.1.1.3 Roles 89

3.4.1.1.4 Affective responsiveness 91

3.4.1.1.5 Affective involvement 93

3.4.1.1.6 Behaviour control 94

3.4.2 The McMaster Family Assessment Device (FAD) 96

3.4.2.1 Description 96

3.4.2.2 Scoring 97

3.4.2.3 Adequacy of instrument 97

3.4.2.3.1 Reliability and criterion validity 97

3.4.2.3.2 Social Desirability 98

3.4.2.3.3 Test-retest reliability and concurrent validity 98

3.4.2.3.4 Discriminative validity 99

3.4.2.3.5 Health/pathology cut-off scores 99

3.5 Procedure 102

3.6 Scoring 103

3.7 Statistical methods 103

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

The present study was designed as a retrospective exploratory study into the family functioning of the families of bulimics, using a systems approach. As this is an exploratory study and no clearcut expectations are held as to the pathology or adjustment of these families, a control group was not considered. In addition, as trends were investigated, no cause-effect statements are made.

Thus this study is primarily descriptive in nature as it seems of importance to first investigate and describe the interactions and transactions within these families before aetiological factors can be delineated. It is suggested that this study may serve as the basis for future research in this area which will include the delineation of aetiological factors.

This chapter will deal with methodological aspects of this study. Discussion will focus on important methodological issues, the sample population and measures and procedures used for data collection and interpretation.

3.2 METHODOLOGICAL ISSUES

3.2.1 Retrospective method

Retrospective method has for a long time been traditional in psychiatry, despite an awareness, even by Freud himself, that this mainly gives information about the current meaning of the recollection (Zeitlin, 1986).

More objective techniques use contemporary data (recorded at the time of occurence) provided by someone other than the subject, although these techniques are not without conceptual and methodological problems (Zeitlin, 1986).

While the recording of contemporary data is assessed by most authors of research design to be a more reliable method of data collection than the retrospective method (Kazdin, 1980), in the present study this would have required a longitudinal study involving the bulimics' families to obtain the overall tone of family functioning, prior to the individuals developing bulimia. Clearly, a predictive approach and clearly impossible within the scope of this thesis. Thus, the retrospective approach was employed.

Nevertheless the many criticisms that have been levelled at this method need briefly to be mentioned.

Yarrow et al (1970) have comprehensively addressed these issues in their article, "Recollections of childhood: a study of retrospective method", but with reference to this study, the following issues in particular need to be borne in mind:

(i) distortions in reporting (Chess et al, 1966) due to "forgetting", that is, interference due to anxiety; changed cues - recall of events under circumstances that differ substantially from those under which they first occurred; avoidance of thinking about unpleasant experiences; incompatibility with cognitive organization - expectations about situations determining what will be recalled about them.(Maher, 1970).

(ii) time alone appears to rapidly decrease the accuracy of recall of "hard data" such as the year in which significant events took place (Barraclough and Brunch, 1973).

(iii) the effects of illness and no doubt treatment appear to affect the recall of actual events (Wardell and Balinson, 1964).

(iv) changes occuring within the individual over time may affect recall. According to Kazdin (1980), it is quite possible that historical events occurring over time or maturational processes can affect recall since these are likely to change the individual's perception of an event.

A further issue then arises as to whether family functioning may be assessed retrospectively. This approach appears to have been used extensively (Quinton et al, 1976; Brown and Rutter, 1966; Saayman and Saayman, 1985; Cunningham and Saayman, 1984) but Brown and Rutter (1966) have indicated that the following issues should be addressed in order to increase the reliability and validity of the data.

First, there is the issue of time to be covered. They suggest that the shorter the time period which is retrospectively assessed, the less in-accurate the information obtained. In this study, various time periods were assessed so that accuracy of the data will no doubt differ.

Secondly, they suggest that either the "retrospective past" (in which a respondent reports about an event from the vantage point of the present) or the "introspective past" (in which the respondent reports from the same point of view as the event) may be assessed. They suggest that "introspective" reporting is more reliable since the individual then relives the past, and during it spontaneous expression of feeling would be expected to be common. Brown and Rutter (1966) suggest that the individual's expression of positive and negative feeling, both verbally and non-verbally, in the interview itself be recorded in order to support the individual's self-reports of events and feelings. In this study, an attempt was made to assess the "introspective past" and affective expression recorded in order to provide a comprehensive report of past events.

Lastly, the issue arises as to whether the specific instrument chosen to assess family functioning in this study, namely the McMaster Model of Family Functioning, provides an accurate retrospective assessment of family functioning. Epstein and Bishop (1983), are satisfied that the model may be used in a retrospective fashion (Saayman, personal communication) and in fact the model has been used in this manner by Cunningham and Saayman (1984) in their investigation into the functioning of dual-career families and Saayman and Saayman (1985) who assessed family functioning from the inception to the termination of the marriage, a period averaging 12, 1 years, with a range of 2 - 24 years.

However, it is obvious that the issues pertaining to retrospective method nevertheless will affect the data obtained.

3.2.2 Interview and self-report questionnaire

Both the interview technique and the self-rating questionnaire have been used extensively as a method of family assessment (Quinton et al, 1976).

While there is no doubt that interviews with all family members are able to provide richer and more detailed information than questionnaires and have been shown capable of providing reliable and valid measures of many aspects of family life and relationship (Brown and Rutter, 1966), they could not be obtained with the families of bulimics. Initially, bulimics were approached and their families' participation requested. Almost universally, bulimics declined to participate if direct interviews with their families were required either because bulimics themselves were unwilling to expose their families to the research process or because the families themselves refused direct contact with the researcher.

Thus, an alternative means of obtaining family participation was sought, one which would not require direct contact and whereby information could be collected directly from family members. Since many bulimics had indicated that their families were willing to participate via questionnaires, it was decided that data would be collected from as many family members available as possible, including the bulimics, via the use of the McMaster Family Assessment Device (FAD), a self-rating questionnaire, which is described in detail later.

However, as this instrument is merely a screening instrument, which identifies problem areas in family functioning, it was felt that qualitative data on the family should be obtained; but the only individuals available to give information were the bulimics.

The issue then arises with regard to whether an accurate assessment of the family may be obtained from one family member, since it is likely that different family members may have different perceptions. Epstein and Bishop (1983) take this to mean that there may be genuine differences in view and that no one perception is correct and the others wrong. If this is true, then it would mean that the qualitative data obtained from the bulimics would merely be the bulimic individuals' assessments of family functioning. However, there are various reasons why the index patients' perceptions should not be disregarded.

(i) Very little research appears to have been done on the sufferers' own perceptions and images of their families. Norris and Jones (1979) have suggested that this investigation has important implications for treatment so that the individuals may be aided in forming a more realistic image, so that "genuine psychological as against physical recovery" can occur (p 102).

(ii) Research into both marital and family functioning (Brown and Rutter,

1966; Quinton et al, 1976; Cunningham and Saayman, 1984; Saayman and Saayman, 1985) reveals that there is a high degree of agreement between ratings based on information from different family members. For example, Brown and Rutter's (1966) findings revealed a correlation of 0,82; Quinton et al's (1976) longitudinal study revealed correlations ranging from 0,78 - 0,67. A significant finding for this study was Quinton et al's (1976) finding that family ratings by the index patient showed no significant difference from those of other family members and that ratings did not differ by the sex of the informant.

Cunningham and Saayman (1984) and Saayman and Saayman's (1985) research using the McMaster Model of Family Functioning reveals that different family members agree with regard to their perceptions of family functioning (Saayman, personal communication). With this in mind, it seems that, while the qualitative data obtained in this study is based on only one member's perceptions in each family, the bulimics' perceptions may well reflect a realistic account of family functioning.

As family data discussed in this thesis has been derived from self-report measures, it is important to assess the adequacy of these methods and the limitations imposed on the quality of the information obtained. Many practical advantages account for their wide use. Self-report measures permit assessment of several aspects of behaviour that are not readily available with other assessment techniques (Kazdin, 1980). Thus in this study, the individual family members were in a unique position to report on their own experiences within their families, without the interference of other members' perceptions. A comprehensive portrait of the family by each member may thus be obtained.

A second aspect of the convenience of self-report measures is their ease of

administration (Kazdin, 1980). In this study, family members' refusal to have direct contact with the researcher could have meant that their perceptions of family functioning were not considered. With the use of the FAD however, these perceptions were able to be recorded.

An important advantage of self-report instruments, particularly for this study, is that they allow some measure of anonymity to be preserved by the families. This appeared to be of importance for the family members of bulimics since they often gave pseudonyms and indicated their relationship to the bulimics, rather than their own names.

Self-report measures obviously evidence limitations, for example, they are candidates for distortion on the part of subjects (Kazdin, 1980). This means that subjects may alter their responses to such a degree that their answers are untrue, in order to satisfy their own motives or self-interest.

Social desirability, for example has been shown to be extremely pervasive on self-report measures. It is important therefore to note that Epstein and Bishop's (1983) research indicates that social desirability does not appear to exhibit a strong influence on FAD scores.

A further problem to consider is that of the actual terminology used in these questionnaires and the tendency for respondents to interpret terms idiosyncratically, unless those terms are clearly and unambiguously defined. Thus, for example FAD statements such as "we are reluctant to show our affection for one another"; "some of us just don't respond emotionally"; or "we do not show our love for one another," are obviously open to individual interpretation.

Self-report measures also appear to be vulnerable to response-style biases of individual respondents. People have shown a tendency to agree or disagree with items regardless of their content (Kazdin; 1980), to check extreme

values on rating scales, such as the FAD; to give cautious answers; or to be inconsistent across items.

The extent to which distortion may occur is thus a function of many factors and Kazdin (1980) has suggested that conditions for responding be arranged so as to minimize distortion. These include preserving anonymity, ensuring confidentially and conveying to the individual that his best interests are served by honest-evaluation - all of which were attempted with the FAD. Provided the limitations of such an instrument are acknowledged, the value of a questionnaire like the FAD lies in that it may be used for screening for family dysfunction in families unavailable for interviewing.

3.3 SUBJECTS

Due to the greater occurence of bulimia in females (80 to 90 % of bulimics are female, versus 10 to 20 % male) (Halmi et al, 1981; Stangler and Printz, 1980) the male population of bulimics was not considered and the study was limited to a female population.

Various sources were approached with regard to obtaining the participation of female bulimic individuals:

(i) Psychiatric services, such as mental health professionals in private practice, mental health professionals at Groote Schuur Hospital and Student Health, University of Cape Town, were approached directly by the researcher and asked to refer bulimic individuals who agreed to participate in research into the families of bulimics.

(ii) The University of Cape Town (UCT) Ballet School and the Cape Performing Arts Board Ballet Company (CAPAB). These organizations were approached

directly by the researcher as it has been suggested by Garner and Garfinkel (1980) that individuals who are dancers are those "who by career choice must focus increased attention and control over their body shapes" (p 647). They found that anorexia nervosa and disturbed eating attitudes were overrepresented in the dancers, suggesting that both pressures to be slim and achievement expectations are risk factors in the development of eating disorders. It was hypothesized that individuals predisposed to the development of bulimia might choose this method of weight control in an attempt to control their body shapes.

Swartz (1985), in his analysis of anorexia nervosa as a culture-bound syndrome, has however discussed the question of whether the choice of a certain career may in itself be a sign of problems. He raises the possibility that in certain subgroups where the symptoms of eating disorders are the norm, it may be that these symptoms have different meanings for such groups than for others, so that the associated psychopathology may not apply.

He suggests that the social content of symptoms should not be reduced to psychopathology and that individuals should not be indiscriminately labelled as exhibiting pathology.

With this in mind, it is important to note that the 3 ballet dancers who participated in the research, identified themselves as bulimic, exhibited <u>all</u> symptoms designated by the DSM - III as being symptomatic of bulimia, and had suffered from bulimia prior to their adopting ballet dancing as a career.

(iii) Newspaper and Magazine Referrals. Several newspapers and magazines (national coverage) were approached by letter, asking for the

publication of a standard article (Appendix 1) which invited bulimics and their families to participate in the research;

(iv) Colleagues at the University of Cape Town Psychology Department presently doing research into eating disorders were asked for referral of bulimic individuals who would be prepared to participate in research into the families of bulimics.

Subjects for the present study were 13 Caucasian females exhibiting all symptoms designated by the DSM - III as being symptomatic of bulimia and the families of 10 of these women.

Details of these subjects are tabulated in Table 3.

The modal social class status of individuals and their families was upper middle class. Sample-wide means for family size, current age of mother, and current age of father were 3,15 siblings, 52,8 years and 52,4 years respectively. 10 of the subjects were no longer living with their parents. Of these, 3 were married or cohabiting with their boyfriends and 2 were the mothers of young children.

The following information enlarges upon tabulated data in Table 3:

10 individuals were from intact families. Both parents of subject number 8 are dead, as are the fathers of subjects 4 and 6.

The parents of subject number 11 refused participation on the grounds that they had experienced "enough trauma"; the parents of subject number 1 were not available for participation as they live overseas; the mother of subject number 4 was not available for participation as she was in poor health in an old age home. 8 siblings did not participate as geographical distance made

TABLE 3

SUBJECT CHARACTERISTICS

SUBJECT NUMBER	SOURCE	AGE	DURATION OF BULIMIA (YEARS)	FAMILY PARTICIPATION	SIBLING'S AGES	PREMORBID WEIGHT (% MPMW) a)	PRESENT WEIGHT (% MPMW) a)	TREATMENT	ONSET OF SYMPTOMS	INSTRUCTIONS RE F A D
1	MAGAZINE	28	9	NIL	NO CONTACT	115	94	b	AFTER DIVORCE AND IMMIGRATION	e
2	CAPAB	22	4	MOTHER, FATHER, 2/3 SIBLINGS	26 19	95	78	d	LEAVING HOME, 1 ST YEAR UNI-VERSITY	e
3	MAGAZINE	29	12	MOTHER,FATHER, 0/3SIBLINGS	NO CONTACT	100	96	bc	LEAVING HOME, 1ST YEAR COLLEGE	e
4	MAGAZINE	35	7	NIL	NO CONTACT	118	101	d	END OF RELATION-SHIP & RELOCATION	e
5	COLLEAGUE	23	5	MOTHER,FATHER, 2/2 SIBLINGS	28 26	87	87	d	LEAVING HOME, 1ST YEAR UNIVER-SITY	e
6	NEWSPAPER	22	7	MOTHER,2/2 SIBLINGS	30 25	116	103	d	LEAVING HOME,1ST YEAR UNIVERSITY	e
7	CAPAB	26	11	MOTHER,FATHER, 2/3 SIBLINGS	32 30	86	77	bd	LEAVING HOME, BOARDING SCHOOL	e
8	MAGAZINE	30	12	NIL	NO CONTACT	111	119	-	LEAVING SCHOOL, AND PARENTS DEATH	e
9	MAGAZINE	17	5	MOTHER,FATHER, 1/1 SIBLING	21	105	93	-	COMMENCING HIGH SCHOOL	f
10	COLLEAGUE	16	3	MOTHER,FATHER, 2/2 SIBLINGS	18 15	103	101	d	COMMENCING HIGH SCHOOL	f
11	UCT BALLET SCHOOL	19	3	2/2 SIBLINGS	26 24	80	106	b	LEAVING HOME, WORKING OVERSEAS	e
12	NEWSPAPER	19	6	MOTHER,FATHER, 1/1 SIBLING	18	108	100	b	COMMENCING HIGH SCHOOL	f
13	MAGAZINE	17	3	MOTHER,FATHER, 1/3SIBLINGS	24	96	117	-	COMMENCING HIGH SCHOOL	f
N=13		X̄=23,3	X̄=6,3			X̄=102	X̄=98			

KEY:

a) MPMW reflects Matched Population Mean Weight, assessed according to general population weight norms for age and height.

b) Previous treatment

c) Present treatment

d) Considering treatment

e) Rate the general tone of your family's functioning during the time (the subject) was living at home

f) Rate the general tone of your family's functioning during the time (the subject) was at Junior School.

NOTE:

"Treatment" refers only to treatment received individually by the bulimic. No families recieved family intervention.

contact difficult; 1 sibling did not participate due to a poor relationship with the bulimic individual (subject number 4).

The 3 individuals whose families were either not available for participation or had refused participation were not excluded from the study as they still provided valuable qualitative information on their families (subjects 1,4 and 8).

There is no history of psychiatric disorder or treatment in family members of any of the subjects.

An issue that needs addressing at this point, is the fact that the 13 subjects represent a mixed group with respect to their treatment histories:

5/13 individuals had received previous treatment, one of whom was presently receiving treatment, while another was considering further treatment; 3/13 individuals had never received treatment and were not seeking treatment; and 5/13 individuals had not previously received treatment and were presently considering treatment.

While it seems likely that therapeutic intervention will alter the individual's perceptions of her family, it is interesting to note that no individuals who had received therapy perceived their family organization and functioning as pathological. While all subjects described problems within certain family dyads, no subject perceived overall family functioning as abnormal or unhealthy. No subject related her bulimia to family functioning; instead all subjects saw their illness as originating within themselves and being due to personal inadequacies. However, it is also likely that therapeutic intervention may have resulted in some individuals perceiving their families to be less pathological. Although this does not appear to have affected the bulimics' assessment of their families (Table 5), this possibility cannot be excluded.

It was hypothesized that certain individuals seeking treatment, would present information on their families in a different light from those not seeking treatment. In order to counteract the possibility of this perceived demand effect, all subjects were advised on first contact that the aim of contact was research rather than treatment. Some individuals declined to take part in research and were referred by the researcher to mental health professionals for treatment. 5 individuals who took part in the research asked for referral subsequent to interviews and were referred.

No families had previously received family intervention, nor were they seeking intervention. Family members therefore represent an homogenous group of subjects with respect to treatment.

It also seems possible that the extent of family knowledge of the bulimics' eating disorder may influence family members' perceptions of their families. The sample represents a mixed group with respect to family knowledge of the eating disorder. Of the 10 families who participated in the research, 2 were aware that the subject had an eating/weight problem (subject numbers 2 and 3); 7 were aware that the subject had bulimia (subject numbers 5, 6, 7, 9, 10, 11, 12); and 1 family had no knowledge of the individual's symptoms (subject number 13). However, family knowledge did not appear to influence family members' perceptions of family functioning as no clear trend emerged with regard to family ratings. Further research may however delineate such trends if more stringent controls are introduced.

3.4 MEASURES

3.4.1 The McMaster Model of Family Functioning (MMFF) (Epstein and Bishop, 1981)

This model has evolved over a period of 20 years and developed from ideas gained from family literature. The concept was then tested in clinical work, in research and in teaching. It has been found to be pragmatic and has been used extensively in psychiatric practice, in therapeutic practice, and in family therapy training programmes.

This model was chosen for various reasons:

(i) It provides a conceptual framework for assessing and diagnosing family functioning according to a systems approach. In this approach, the family is seen as an open system, consisting of various subsystems (individual, marital, dyad) which relate to other systems (extended family, schools, occupation, religion). Explicit rules plus action by members are seen as governing the individual family members' behaviour. In this approach, the concern is with processes occurring in the family system which produce the behaviour labeled "pathology".

(ii) Various theories are drawn on (communication, learning, transactional) although the underlying assumptions are those of systems theory:

1. The parts of the family are interrelated.
2. One part of the family cannot be understood in isolation from the rest of the system.
3. Family functioning cannot be fully understood by simply understanding each of the parts.
4. A family's structure and organization are important factors determining the behaviour of family members.
5. Transactional patterns of the family system shape the behaviour of family members." (Epstein and Bishop, 1981, p446).

(iii) The approach to families is rooted in the Judaeo-Christian value system, emphasizing the optimal development of each human being. Since it was hypothesized that most of the individuals would hold to this value-system, this model was considered to provide adequate appreciation thereof.

3.4.1.1 Description

Epstein and Bishop (1981) postulate that the family is a container for the social, psychological and biological development and maintenance of its members. Issues and problems dealt with by the family are perceived to be in the following areas:

(i) Basic task area including instrumental and fundamental issues, such as provision of food, money, transportation and shelter.

(ii) Developmental task area, including family issues arising out of individual and family growth over time:

a) individual developmental stages, for example, infancy, childhood, adolescence, middle and old age crises.

b) family stages, for example the beginning of the marriage, the first pregnancy, and the birth of the first child.

(iii) Hazardous task area, including the crises that arise in association with critical experiences such as illness, accidents, loss of income, job changes and moves.

Task areas are deemed to be important as clinical presentation has been found to be associated with the family's inability to deal effectively with some of these areas.

Several dimensions are delineated to describe the family structure, organization and transactional patterns often associated with family difficulties: problem solving, communication, roles, affective responsiveness, affective involvement and behaviour control.

The authors note that although the model does not cover <u>all</u> aspects of family functioning, is does identify a number of dimensions found to be important in clinically presenting families. Although researchers such as Haley conceptualize family behaviour as occurring within a single dimension, communication, Epstein and Bishop (1981) argue for a multi-dimensional approach in order to fully understand the complexities of the family.

The model as set forth by Epstein and Bishop (1981, pp 444-482) is described overleaf:

3.4.1.1.1 Problem solving:

defined as a family's ability to resolve problems so that effective family functioning is maintained. Problems are perceived as being those that threaten the functional capacity of the family, the solution to which presents difficulty.

Effective families appear to solve their problems, whereas ineffectively functioning families appear to have difficulties dealing with at least some of their problems.

Problems are subdivided conceptually into instrumental and affective types. Instrumental problems are the mechanical problems of everyday life, such as money management. Affective problems are those related to feelings.

Families which have difficulty in resolving both types of problems are perceived as functioning least effectively; those with difficulties in resolving only affective problems are more effective and families which resolve both types are perceived as being most effective.

Attempts at solving problems are operationally defined in a sequence of seven stages by the model:

(i) The problem identification stage includes determination of who identifies the problem, the pattern of identification and whether or not there is correct identification of the problem.

(ii) The communication of the problem stage considers to whom the identified difficulty is communicated and whether that was an appropriate person.

(iii) The alternative action stage considers the types of plans considered and how they vary with the nature of different problems.

(iv) The decision on a suitable course of action stage considers whether the family can make decisions, whether alternatives are considered or if action is predetermined, and whether those involved in the action are informed of the decision.

(v) The action stage considers the degree to which the family acts on its decisions - whether they act at all, in a limited way or carry out all aspects of the plan.

(vi) Monitoring the action refers to whether or not the family has a "built-in accountability mechanism" (Epstein and Bishop, 1981, p 457) to check whether decisions were acted upon and carried out.

(vii) Evaluating the success of actions involves a review by the family of their problem-solving ability in order to learn from experience, to evaluate which are the most effective mechanisms and to take cognisance of inappropriate behaviour.

Epstein and Bishop postulate that the more effective a family's functioning, the more steps of this process it can negotiate.

3.4.1.1.2 Communication:

defined as the exchange of information among family members, with the focus being on verbal exchange. Epstein and Bishop exclude the nonverbal aspects from assessment because of possible misinterpretation and methodological difficulties of collecting and measuring such data for research purposes.

Communication is subdivided into instrumental and affective areas. While some families exhibit marked difficulties with affective communication although functioning very well with instrumental communication, the reverse is rarely seen.

The style of communication is also assessed and four styles are described:

(i) Clear and direct

(ii) Clear and indirect

(iii) Masked and direct

(iv) Masked and indirect

The question of clear or masked focuses on the clarity with which the content of the information is exchanged. The question of direct or indirect considers whether the message goes to the person for whom it is intended.

It is postulated that the more masked and indirect the overall family communication pattern, the more ineffective the family's functioning; the more clear and direct the communication, the greater its effectiveness.

3.4.1.1.3 Roles:

defined as the recurrent patterns of behaviour by which family members fulfill functions.

Family functions are divided into instrumental and affective areas. In addition, the functions are further subdivided into necessary and other family functions.

Necessary functions include those essential to the effective functioning of the family - these may be instrumental, affective or a combination of the two. Other family functions are not perceived as being essential for effective family functioning, but arise in the life of every family. These may be adaptive or maladaptive and may be unique to each family.

Necessary functions are seen as including the following five tasks:

(i) Provision of resources. This refers to the accomplishment of such instrumental tasks as provision of food, clothing, shelter, money and transport.

(ii) Nurturance and Support. This consits of the affective tasks of providing family members with support,care,reassurance and comfort.

(iii) Sexual gratification of marital partners refers to the sexual functioning of the partners with the emphasis on their ability to gratify each other, and the focus is the affective result of their sexual relationship.

As parents were not interviewed and thus could not comment on this aspect of family functioning, only a broad outline of the parental relationship was requested of the bulimic.

(iv) Life Skills development. This includes those instrumental and affective functions encompassing children's educational tasks, adults' vocational interests and those tasks required to obtain individuals' optimum level of personal development.

(v) Maintenance and Management of family systems involves such functions as leadership, decision-making and the handling of family finances. It also includes the function of maintaining the family system of boundaries with respect to extended family as well as the extra-familial. Maintenance of family standards is also considered and includes such tasks as disciplinary action, monitoring, labelling and identifying relevant behaviour within the family.

Two other concepts are also considered:

(i) Role Allocation which refers to the assignment of responsibility for family functions and whether appropriate or inappropriate, implicit or explicit, autocratically or democratically assigned and whether these responsibilities are shared among members or laden onto already overburdened persons; and

(ii) Role Accountability which involves the process of monitoring allocated tasks. Well-defined accountability reinforces the person's commitment to doing a task and the effectiveness with which it is executed.

It is postulated that the healthier families are those in which most, if not all of the family functions are adequately fulfilled and the allocation and accountability processes are most clear.

3.4.1.1.4 Affective Responsiveness:

defined as the ability of the family to respond to a range of stimuli with the appropriate quantity and quality of feeling.

With regard to quality, the focus is on the ability of members to respond with the full spectrum of feelings experienced in human emotional life, the emotion experienced being consonant with the stimulus in context. With regard to quantity, the focus is on the degree of response, extending from non- or underresponsiveness to overresponsiveness.

While this dimension measures the degree of appropriate experiencing of feelings, the dimension of communication (affective) refers to how family members transmit to each other the emotions experienced individually.

This dimension thus considers the pattern of the family's responses to affective stimuli. For an effective family life, it is postulated that the potential for the full range of affective experiences that are appropriate in quality and quantity of response will be present. For unless an individual experiences an emotional response, he/she cannot communicate it.

Responses are divided into two classes:

(i) Welfare feelings / emotions which are exemplified by responses such as love, tenderness, happiness, and joy.

(ii) Emergency feelings by fear, anger, sadness, dis appointment, and depression.

A family which responds appropriately with love and tenderness but never anger, sadness or joy, would be considered restricted, and this may well result in the children developing affective constriction, which might strongly influence their personal development.

3.4.1.1.5 Affective Involvement:

defined as the degree to which family members show interest in and place value on each other's activities and concerns. The focus is on how much and in what way family members show an interest in and invest themselves in each other.

Their degree of involvement proceeds through the following range:

(i) Absence of involvement: Members show no interest or investment in each other, their only involvement being their shared instrumental functions.

(ii) Involvement devoid of feelings: Families show some intellectual interest, but there is little investment of the self or feelings in the relationship. This interest and investment is demonstrated only when demanded and even then may be minimal.

(iii) Narcissistic Involvement occurs when the investment in others is primarily egocentric and there is no feeling of the meaning a particular situation holds for others.

(iv) Empathic involvement, the most effective type, refers to an emotional investment in other members in which each member cares deeply about the significant activities and involvements of the others.

(v) Overinvolvement is an overintrusive, overprotective, often overly warm type of involvement which may be disconcerting or troublesome despite it being well-meant.

(vi) Symbiotic involvement refers to those pathological states where the involvement is so intense that the boundaries between individuals are blurred. This type of involvement is seen only in seriously disturbed relationships.

Empathic involvement is viewed as the most effective form of affective involvement; involvement devoid of feelings, narcissistic or overinvolvement less so, and lack of involvement or symbiotic involvement least effective.

3.4.1.1.6 Behaviour Control:

defined as the way in which a family expresses and maintains standards for the behaviour of its members.

Behaviour in three types of situations is assessed:

(i) Physically dangerous situations. This is where the family has to monitor and control the behaviour of its members, such as children moving into dangerous surroundings, or in the case of adults, preventing reckless behaviour.

(ii) Situations involving meeting and expressing psychobiological needs or drives, such as eating, sleeping, eliminating, sex and aggression.

(iii) Situations involving interpersonal socialising behaviour both among family members and with people outside the family where patterns of acceptable behaviour may differ.

Families develop their own standards of acceptable behaviour as well as the degrees of latitude which they will permit in relation to these standards. This determines the following styles of behavioural control:

(i) Rigid Control: standards are very constricting and little latitude is allowed for negotiation and change in any situation.

(ii) Flexible Control: standards are reasonable and flexible, depending on the context.

(iii) Laissez-Faire control: no distinct standards exist and extreme latitude is permitted so that "almost anything goes" (Gurman and Kniskern, 1981, p 466).

(iv) Chaotic control: there is no consistent style and styles shift between rigid, flexible and laissez-faire unpredictably.

Flexibile behaviour control is perceived to be the most effective style, then rigid, laissez-faire and finally chaotic.

Techniques to enforce acceptable behaviour and the application thereof are considered on the Roles dimension.

With respect to each dimension, there are clear operational criteria according to which a family can be qualitatively and quantitatively evaluated on the effectiveness of its functioning, ranging from most ineffective to most effective functioning.

The McMaster Clinical Rating Scale (CRS) evaluates families according to the McMaster Model of Family Functioning and provides the quantitative data with respect to the 7 dimensions of the MMFF, as well as providing a rating for the Overall Family functioning.

Each dimension is rated on a seven-point scale on which 1 is severely disturbed functioning and 7 superior functioning. A rating between 1 and 4 on any scale indicates that an individual within the family or the family as a whole is

likely to need clinical help. A rating between 5 or 7 on any scale indicates that disturbances in that area are minor and unlikely to lead to a need for clinical help.

A clinical manual, the McMaster Clinical Rating Scale, developed by Epstein, Baldwin and Bishop in 1982, lays down clear operational criteria for ratings.

A definition of the concepts involved in each dimension of functioning is provided; there is a description of the family characteristics at three levels of functioning: severely disturbed (1); non-clinical (5); and superior (7); and finally, there is a set of principles for rating that can also be used to rate the family along the seven-point scale.

Ratings reflect the family system's functioning as a unit, rather than individuals or a summary of individual characteristics. Although one or two family members may have difficulty with a dimension, the family as a whole may function very effectively as other members may compensate for individual problems.

3.4.2 The McMaster Family Assessment Device (FAD)

3.4.2.1 Description

The FAD was developed by the Butler/Brown Family Research group (Epstein and Bishop, 1983) (Appendix 4).

It is a 53 item, self-report scale designed to assess the same seven dimensions of family functioning as the Clinical Rating Scale. Six of the scales of the FAD reflect the dimensions of family functioning outlined in the McMaster Model of Family Functioning (Epstein and Bishop, 1981). Additionally, a General

Functioning dimension which assesses overall health/unhealth is included. ("Health"; "unhealth" are terms used in the MMFF and not those developed by the researcher).

The FAD contains a series of statements reflecting the model's characterization of families. All family members (over age 12) are given the instrument, and for each statement, each person rates the extent to which it describes the family. These are then scored by the researcher to provide both individual and family ratings of family functioning.

3.4.2.2 Scoring

Items are scored so that 1 represents a healthy response and 4 represents an unhealthy response. All responses are scored as follows:
Strongly Agree = 1; Agree = 2; Disagree = 3; Strongly Disagree = 4.
Then the scores for items describing unhealthy functioning are transformed by subtracting them from 5.

This inverts the response scales on the unhealthy items so that strongly agree responses on an unhealthy item are equaled with a strongly disagree response to a healthy item. The scored responses to the items of each scale are averaged and provide seven scales, with scores each having a possible range from 1,00 (healthy) to 4,00 (unhealthy).

3.4.2.3 Adequacy of Instrument

The Brown/Butler Family research Group appear to have provided much evidence for the utility of the FAD. These findings are discusses below:

3.4.2.3.1 Reliability and Criterion Validity

Items for the FAD were chosen from separate items pools for each of the six dimensions of the MMFF and were selected for inclusion on the basis of their internal consistency and independence. This procedure yielded seven scales with internal consistency estimates ranging from 0,72 to 0,92. The seven scales evidenced correlations between 0,4 and 0,6 but when the effects of the General Functioning scale were removed, the remaining six scales appear relatively independent of each other (Epstein and Bishop, 1983).

In addition, these researchers using the FAD were able to distinguish between clinical and non-clinical families, that is, between families where one member was a psychiatric patient and families with no psychiatric history. By knowing a family's score on the FAD, they correctly identified 60 % of clinically presenting families as being in that category and 69 % of the non-clinically presenting families; overall a 65 % correct identification of families by category.

3.4.2.3.2 Social Desirability

When FAD scores were correlated with scores on a Scale measuring Social Desirability, correlations were found to be uniformly low, ranging from -0,06 to -0,19, across all scales. Hence, Epstein and Bishop (1983) concluded that social desirability does not appear to exert a strong influence on FAD scores.

3.4.2.3.3 Test-Retest Reliability and Concurrent Validity

When the FAD and two other self-report family assessment measures were administered to non-clinical individuals and the FAD readministered one week later, test-retest estimates for the FAD scales ranged from 0,66 to 0,76, which the researchers felt indicated that the FAD had adequate reliability over time.

However, Epstein and Bishop's (1983) figures are those for a non-clinical sample, whereas this research is concerned with individuals who manifest a psychiatric condition. The fact that the FAD, although it has been extensively used on clinical populations, has not been test-retested on a clinical sample, should be borne in mind in the interpretation of the present research data.

The same problem applies to the concurrent validity of the FAD. The same non-clinical sample as above was used to assess the concurrent validity of the FAD by administering the FAD and the FACES II and Family Unit Inventory (Epstein and Bishop, 1983) to these subjects. The researchers suggest that the FAD correlates moderately well with these other self-report measures of family functioning, providing good evidence for the concurrent validity of the FAD. For a more detailed discussion of the statistical analyses, interested readers are referred to Epstein and Bishop's (1983) paper.

3.4.2.3.4 Discriminative Validity

When the FAD scores of a clinical family (the family score being obtained by combining individual scores to obtain the family mean) were compared with a family therapist's clinical ratings of the same family, analyses indicated that the families rated by a clinician as unhealthy on a given dimension had significantly higher family FAD scores on that dimension for every dimension except Behaviour Control, which approached significance. These analyses suggest that the FAD scores correspond to clinicians' ratings of families as "healthy" or "unhealthy", on six of seven specific dimensions.

3.4.2.3.5 Health/Pathology Cut-off Scores

Epstein and Bishop (1983) originally suggested that since FAD response

categories range from 1 to 4, a mean of greater than 2,0 indicates a greater preponderance of unhealthy items. This suggests that the family are having difficulty with this area of functioning. Thus in establishing cut-off scores, from a theoretical and content perspective, a cut-off score greater than 2,0 seemed ideal.

However, in an attempt to maximise sensitivity (proportion of actual "abnormal" results accurately identified by the test) and specificity (proportion of actual "normal" results correctly identified by the test) for each FAD, as well as taking into account actual means of unhealthy families studied, the cut-off scores marked "original" in Table 4 were chosen. The researchers felt that these scores have acceptable rates of sensitivity (57 to 83 %) and specificity (64 to 79 %) as well as high rates of diagnostic confidence (proportion of "abnormal" scores which are true positives) (68 to 89 %). These results appear to be similar to other assessment instruments (Epstein and Bishop, 1983).

Two other cut-off points for each dimension were formulated to allow researchers the choice of alternative specificity and diagnostic confidence levels within the range indicative of unhealthy functioning (Table 3). This means that all scores above the lowest FAD cut-off point are indicative of unhealthy functioning, at different levels of diagnostic confidence.

Epstein and Bishop (1983) also found that non-clinical families were found to have significantly higher proportions of healthy scores on all dimensions except Behaviour Control. Thus the FAD cut-off scores appear to discriminate significantly between psychiatric and non-clinical families.

It is also possible however, that a substantial proportion of families without an identified problem will manifest some dysfunction on one or more dimensions, and this was supported by their findings of 19 to 36 % of non-clinical families

TABLE 4

FAD CUT-OFF SCORES

		Cut-off	Sensitivity	Specificity	Diagnostic Confidence
Problem Solving	(original)	2,2	0,70	0,79	0,87
	(alternative)	2,3	0,85	0,79	0,84
		2,1	0,59	0,57	0,79
Communication	(original)	2,2	0,83	0,73	0,87
	(alternative)	2,3	0,90	0,91	0,95
		2,1	0,67	0,55	0,84
Roles	(original)	2,3	0,63	0,64	0,85
	(alternative)	2,4	0,93	1,00	1,00
		2,1	0,48	0,36	0,74
Affective Responsiveness	(original)	2,2	0,63	0,64	0,77
	(alternative)	2,4	0,82	0,86	0,89
		2,0	0,59	0,43	0,73
Affective Involvement	(original)	2,1	0,81	0,60	0,68
	(alternative)	2,4	0,91	0,81	0 64
		2,0	0,33	0,40	0,61
Behaviour Control	(original)	1,9	0,57	0,67	0,68
	(alternative)	2,1	0,74	0,89	0,78
		1,8	0,31	0,44	0,63
General Functioning	(original)	2,0	0,67	0,64	0,83
	(alternative)	2,2	0,67	0,64	0,83
		1,8	0,50	0,45	0,81

manifesting scores in the unhealthy range on a given FAD scale.

Similarly, the findings were that a proportion of families with a severely disturbed member may not show dysfunction or may even show healthy functioning although there may be some area of difficulty (32 to 54 %).

Bearing this in mind, it seems possible nevertheless, to screen effectively for family dysfunction on at least six of the seven dimensions and in some cases even identify the presence of significant dysfunction.
It is for this purpose that the FAD will be used in the present study.

3.5 PROCEDURE

The process of data collection for this thesis encompassed three stages:

(i) A focused clinical interview with each bulimic individual was conducted to obtain biographical information and a chronological account of the development of the eating disorder in order to confirm a diagnosis of bulimia according to DSM - III criteria (Appendix 2, Phase 1).

(ii) Since bulimics had declined to participate if direct contact with their families was required (see 3.2.2), the researcher requested that the bulimics ask their families to participate in the study via questionnaires. Once the bulimics had indicated that their families were willing to participate, a covering letter outlining the rationale for this study, together with the FAD's for all family members, (Appendices 3 and 4) were posted to the parents of bulimics who had agreed to participate in the study. At the same time, each bulimic individual was asked to complete a FAD and return this to the researcher.

The family members were requested to rate the FAD's retrospectively and

instructions differed, depending on the onset of the bulimic's symptoms (Table 3). In this way, premorbid family functioning for all bulimics was assessed,thus ensuring standardization of data.

(iii) Once these questionnaires had been returned to the researcher, a semi-structured interview, retrospective in nature, was conducted with the bulimic individuals whereby their perceptions of their family's functioning were assessed according to the McMaster Model of family functioning. An outline of the questions asked is provided in Appendix 2, Phase 3.

3.6 SCORING

Family functioning as assessed via the interview with the bulimic individuals was rated independently (CRS rating) of the additional assessment provided via the scored questionnaires, thus providing some measure of Discriminative Validity as well as controlling for rater bias.

3.7 STATISTICAL METHODS

In order to obtain an overall picture of the sample, the families were divided into groups: mothers, fathers, bulimics and other siblings so that these various groups' ratings could be compared with one another.

Thereafter, a profile of the means and standard errors of the mean for these groups' FAD scores as well as for the ratings on the CRS was drawn up. The cut-off scores for health/unhealth as devised by the Butler/Brown Research Group (Table 4) were then applied to the means, thus providing a picture of the families' and researcher's ratings of healthy/unhealthy family functioning.

In order to compare a clinical rating of an entire family with the FAD, it is necessary to utilize a score which combines all family members' FADs.

Epstein and Bishop (1983) utilized the family mean as a family score in their analyses and this method of combining individual scores to obtain a family score was utilized in the present analyses.

The results of this study, both quantitative and qualitative, will be discussed in the following chapter.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Results 106

4.1.1 Introduction 106

4.1.2 Quantitative analysis 106

4.1.2.1 Overall impression 106

4.1.2.2 Reliability of data 106

4.1.3 Qualitative analysis 109

4.1.3.1 General family functioning 109

4.1.3.2 Problem solving 110

4.1.3.3 Communication 114

4.1.3.4 Roles 116

4.1.3.5 Affective responsiveness 123

4.1.3.6 Affective involvement 125

4.1.3.7 Behaviour control 127

4.2 Discussion 131

4.2.1 Family functioning 131

4.2.1.1 Basic tasks 131

4.2.1.2 Developmental tasks 132

4.2.1.3 Hazardous tasks 135

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 RESULTS

4.1.1 INTRODUCTION

Results obtained in this study are presented and discussed in this chapter. Quantitative data on FAD scores and the CRS are presented in Table 5 and are discussed in the next section. Qualitative data about family functioning obtained from bulimics is also presented and discussed. Particular attention is focused on family patterns and transactions hypothesized to be of relevance in the development of bulimics' symptoms.

4.1.2 Quantitative analysis

4.1.2.1 Overall impression

The overall impression of these families appears to be of unhealthy family functioning. Table 5 reveals that on all dimensions, all groups of individuals' ratings reveal unhealthy family functioning, although the levels of diagnostic confidence with which one is assured of identifying health/unhealth differ (Epstein and Bishop, 1983). This overall view is supported by the researcher's ratings of family functioning, both quantitatively (Table 5) and qualitatively, which reflects familial dysfunction on all dimensions.

4.1.2.2 Reliability of data

TABLE 5

MEAN FAD SCORES FOR ALL FAMILY MEMBERS; FAMILY MEAN SCORES AND CRS MEANS FOR ALL DIMENSIONS

	Mothers	Fathers	Bulimics	Other Siblings	Family	CRS
Problem Solving	$\bar{x}$ = 2,2 ** $\sigma_{\bar{x}}$ = 0,[illegible]02	$\bar{x}$ = 2,1 *** $\sigma_{\bar{x}}$ = 0,113	$\bar{x}$ = 2,7 * $\sigma_{\bar{x}}$ = 0,174	$\bar{x}$ = 2,4 * $\sigma_{\bar{x}}$ = 0,231	$\bar{x}$ = 2,4 * $\sigma_{\bar{x}}$ = 0,153	$\bar{x}$ = 4,0 † $\sigma_{\bar{x}}$ = 0,226
Communication	$\bar{x}$ = 2,3 * $\sigma_{\bar{x}}$ = 0,117	$\bar{x}$ = 2,3 * $\sigma_{\bar{x}}$ = 0,144	$\bar{x}$ = 2,7 * $\sigma_{\bar{x}}$ = 0,144	$\bar{x}$ = 2,6 * $\sigma_{\bar{x}}$ = 0,195	$\bar{x}$ = 2,5 * $\sigma_{\bar{x}}$ = 0,132	$\bar{x}$ = 3,2 † $\sigma_{\bar{x}}$ = 0,191
Roles	$\bar{x}$ = 2,2 *** $\sigma_{\bar{x}}$ = 0,116	$\bar{x}$ = 2,1 *** $\sigma_{\bar{x}}$ = 0,101	$\bar{x}$ = 2,3 ** $\sigma_{\bar{x}}$ = 0,107	$\bar{x}$ = 2,1 *** $\sigma_{\bar{x}}$ = 0,139	$\bar{x}$ = 2,2 *** $\sigma_{\bar{x}}$ = 0,098	$\bar{x}$ = 4,1 † $\sigma_{\bar{x}}$ = 0,077
Affective Involvement	$\bar{x}$ = 2,4 * $\sigma_{\bar{x}}$ = 0,196	$\bar{x}$ = 2,2 ** $\sigma_{\bar{x}}$ = 0,122	$\bar{x}$ = 2,3 ** $\sigma_{\bar{x}}$ = 0,139	$\bar{x}$ = 2,0 *** $\sigma_{\bar{x}}$ = 0,142	$\bar{x}$ = 2,3 ** $\sigma_{\bar{x}}$ = 0,101	$\bar{x}$ = 3,2 † $\sigma_{\bar{x}}$ = 0,154
Affective Responsiveness	$\bar{x}$ = 2,3 ** $\sigma_{\bar{x}}$ = 0,171	$\bar{x}$ = 2,2 ** $\sigma_{\bar{x}}$ = 0,158	$\bar{x}$ = 2,6 * $\sigma_{\bar{x}}$ = 0,224	$\bar{x}$ = 2,3 ** $\sigma_{\bar{x}}$ = 0,215	$\bar{x}$ = 2,4 * $\sigma_{\bar{x}}$ = 0,183	$\bar{x}$ = 2,9 † $\sigma_{\bar{x}}$ = 0,137
Behaviour Control	$\bar{x}$ = 2,2 * $\sigma_{\bar{x}}$ = 0,112	$\bar{x}$ = 1,8 *** $\sigma_{\bar{x}}$ = 0,146	$\bar{x}$ = 2,0 ** $\sigma_{\bar{x}}$ = 0,118	$\bar{x}$ = 2,1 ** $\sigma_{\bar{x}}$ = 0,136	$\bar{x}$ = 2,4 * $\sigma_{\bar{x}}$ = 0,092	$\bar{x}$ = 3,6 † $\sigma_{\bar{x}}$ = 0,213
General Functioning	$\bar{x}$ = 2,2 * $\sigma_{\bar{x}}$ = 0,189	$\bar{x}$ = 2,1 ** $\sigma_{\bar{x}}$ = 0,166	$\bar{x}$ = 2,5 * $\sigma_{\bar{x}}$ = 0,206	$\bar{x}$ = 2,2 * $\sigma_{\bar{x}}$ = 0,183	$\bar{x}$ = 2,3 * $\sigma_{\bar{x}}$ = 0,171	$\bar{x}$ = 3,4 † $\sigma_{\bar{x}}$ = 0,140
	n = 9	n = 8	n = 13	n = 9	n = 10	n = 13

Unhealthy Cut Off Scores: *Disturbance indicated at Highest level of diagnostic confidence

**Midrange level

***Lowest level

† Unhealthy family functioning

The family mean scores on all dimensions also reveal ratings of unhealth. What is significant is that on 5 of the 7 dimensions, disturbance in family functioning is indicated at the highest level of diagnostic confidence with which one is assured of identifying health/unhealth. Although the levels of diagnostic confidence are slightly lower on the remaining two dimensions, Roles (0,74) and Affective Involvement (0,64), according to Epstein and Bishop (1983) all scores above the lowest FAD cut off point are indicative of unhealthy functioning. Hence, all family mean scores are indicative of a disturbance in family functioning.

In addition, it is important to note that the family mean scores accurately reflect family functioning as rated by all family members, since all dimensions are rated as unhealthy by all family members (Table 5).

Although the clinician's ratings of family functioning (CRS) are arrived at via an interview with the bulimic individual (qualitative data), it would seem that it is an accurate assessment of family functioning since the bulimics' ratings of family functioning are no different from any other family member on any dimension with respect to health/unhealth. It is interesting that the bulimics' ratings of family functioning, like the family mean score, indicate a disturbance in family functioning on 5/7 dimensions, at the highest level of diagnostic confidence (Table 5).

Although it is acknowledged that interviews with the various family members could have provided differing qualitative data, it seems unlikely that the clinician's ratings of family functioning would have been affected, since all family members'ratings of family functioning are the same, that is, unhealthy on all dimensions.

4.1.3 Qualitative analyses

This section presents a clinical assessment by the researcher based on the information obtained from the bulimic individuals according to the McMaster Model of Family Functioning outlined in section 3.4.1. In addition, reports from the bulimics themselves are used in the analyses and in these instances actual numbers of families evidencing particular patterns are quoted.

4.1.3.1 General Family Functioning

The superficial impression of these families is that of a "caring" family where individuals are accepted for what they are, where parents provide for their children's "every" need and where all or most members love and make sacrifices for one another. However, not far beneath this idyllic surface, this ethic held to by the family is revealed to be a facade of affective involvement, with actual interaction occuring at an instrumental level. Fathers, although mythically accepted as the head of the house actually appear to be no more than "money makers" and are mostly absent from family interaction. In contrast, mothers are the ones who are in control in the family.

Due to the fact that they often assume dual-parent roles, they are over-burdened and unlikely to provide appropriate nurturance for family members, particularly since they themselves appear to receive little nurturing from fathers and there appears to be some measure of covert parental conflict. The actual involvement of members is markedly narcissistic and it is not therefore unexpected that mothers and bulimics should become overinvolved in their search for nurturance.

While all these families appear to function smoothly at an instrumental level, they evidence major difficulties in dealing with affect and affective issues. They appear to be affectively constricted with regard to both welfare and emergency feelings. Love is an intellectual and practical experience in these families but little or no welfare feelings are verbalised. As far as emergency feelings are concerned, these families appear to attempt to deny the expression of negative feelings, so that "smooth" functioning is ensured, although the families vacillate between constriction and overproduction of anger. This pattern is also evident in the control of members' behaviour and control vacillates between rigid control and flexible or laissez-faire style. These families appear to have difficulty negotiating exchange of control at adolescence so that existing patterns, which appear to prohibit adequate adolescent maturation,remain.

4.1.3.2 Problem Solving

The overall impression is that these families appear to resolve instrumental problems successfully by completing most steps in the problem-solving process.

However with regard to affective problems, the overall impression is that families appear to deny the existence of problems so that resolution of these issues is precluded. Various degrees of problem-solving are in evidence, however, and these are described.

(i) Problem Identification

10/13 bulimics report that the members of their families recognise the existence of both instrumental and affective issues. Mothers appear to be the primary identifiers but other family members also are capable of problem recognition.

In the remaining three families, while instrumental problems are identified, bulimics describe their families as "not really tuned into emotional problems". Conflict is also generated when family members differ as to their perception of the problem (that is, whether instrumental or affective). Thus when affective issues arise, they are often handled as instrumental problems via displacement and/or distortion, or denied. These three bulimics report that their families have difficulty allowing recognition of affective problems and are defensive because they fear making themselves vulnerable and "losing face" if they admit that there is a problem.

(ii) Communication of problem

All bulimics report that instrumental problems are communicated to the more available parent, usually mother. Although half the bulimics report that they would prefer to approach father, this is usually not possible as fathers are perceived as "always busy" or "always working" and individuals fear "bothering father unnecessarily". Thus fathers are often excluded from the problem-solving process, while mothers assume responsibility for informing fathers of instrumental problems on behalf of their children.

All bulimics report that affective problems are not communicated in the family - "they are never brought up", "brushed aside" or "never emerge".

They describe individual handling of affective issues by family members or in dyads (with mothers or other siblings) as they believe that family members are fearful of the negative feelings evoked or conflict generated,due to the lack of containment provided by the family for negative feelings and the fear of vulnerability. Instrumental problems often appear to serve as a catalyst for the emergence of affective problems but conflict appears to be displaced onto instrumental issues.

10/13 bulimics report that parents lack understanding and are unable to handle affective problems. Fathers in particular appear to have difficulty handling emergency feelings. and often view affective matters as "silly" or "irrational" or their "logical" approach to problems and lack of "emotion" result in their daughters refraining from discussing problems with them. Of these 10, 6 bulimics report that mothers expect their children to handle their own problems independently while the remaining 4 report that they refrain from communicating affective issues as mothers "take things as an accusation against her ability as a mother" and "accuse" the bulimics of being dissatisfied with their mothering, thereby evoking guilt in their children.

(iii) Formulation of alternatives

Various approaches to instrumental problems are reported:

While all bulimics report that parents can be relied upon to handle all issues as either parent usually has an "immediate and practical" solution, only 3/13 families appear to discuss alternatives. Bulimics themselves suggest that parents have difficulty seeing themselves as "not coping" and attempt to head off all instrumental problems before the discussion stage.

With regard to affective problems, all bulimics report that parents provide "practical advice and logical alternatives". The adage "pull yourself together....... don't get so emotional" is sometimes used by mothers, and families hardly ever share ideas on ways of handling affective problems. 6/13 bulimics even went so far as to suggest that if the family attempts to discuss alternatives there is instead a "joint venting of emotions about the issue" which leads to conflict and increased defensiveness regarding opening of self to other family members.

(iv) Decision-making

With regard to family decision-making, fathers are seldom involved, although 4 bulimics report that fathers communicate their decisions via mothers and 1 bulimic reports that family decision-making with regard to instrumental issues does occur.

Decision-making often appears to involve only the individual concerned and mother, although 4/13 bulimics report that parents make the decisions for the children and "either you like or lump them". These bulimics report that they lack experience in decision-making and avoid making decisions as they are fearful of the consequences.

Decision-making about affective issues appears to be handled even less effectively: while half the bulimics report that parents make these decisions, "based on practical grounds" the others report no family decision-making and issues remain unresolved, forcing members to cope with these problems alone.

(v) Action

Various patterns of action are reported, once decisions are made:

While half the bulimics report that either parent takes on the task of checking that decisions are implemented, the others report that due to family or parental disagreement, there is no actioning of decisions so that problems re-occur.

(vi - vii) Monitoring and evaluation of actions

Only 2/13 families appear to evaluate their actions, but even then evaluation appears to take place in dyads (either mother and another family member or between siblings). Bulimics from these 2 families report that parents blame circumstances beyond their control, rather than accept responsibility for "wrong" decisions, or discuss affective issues "at an intellectual level". All other bulimics report that success is taken for granted, while failure ignored.

4.1.3.3 Communication

Communication in all these families seems to occur in dyads, particularly with regard to affective issues. When families do discuss issues, this often occurs around the dinner table, where discussion occurs at an instrumental level. Often it is merely the sharing of everyday events and activities and there is no sharing of self or discussion of feelings. Instead there are intellectual or philosophical debates on objective issues and an atmophere of underlying tension associated with the families' efforts to keep discussions at a superficial level to avoid conflict associated with the surfacing of affective issues.

All bulimics report that they believe that their families fear negative emotions as once negative emotions are communicated, individuals become defensive and the risk of conflict is greater. So to avoid family confrontation, these matters are not aired as a family. Other reasons for withholding communication of affect suggested by bulimics are: a fear of "losing face and the rest of the family finding out you are not what they think you are"; that this is not a family pattern; or that "you feel uncomfortable, despite the reassurance from parents that you can say what you want - so you don't because you can't".

Both instrumental and affective communication between parents is either described as masked but direct or clear but indirect. 4/13 bulimics report that mothers discuss the marital relationship with their daughters or communicate via their daughters in the case of parental conflict. This appears to result in these 4 bulimics being placed in an untenable position vis à vis parents as they feel forced to take sides.

The parental pattern of communication appears to be the model for communication in the family. Thus family members seldom communicate their true feelings or intentions directly, so that the intended recipient often fails to receive the message.

All bulimics report the "necessity" for maintaining a facade as they fear being "emotionally cut off" by mothers if they voice feelings which mothers perceive as an accusation against their parenting, and "ridiculed" by fathers if they voice feelings labelled as "irrational".

The expression of both welfare and emergency emotions appears to be masked. All bulimics report that affection is seldom demonstrated or verbally communicated, even between parents. Instead love is an "intellectual" or practical experience, usually expressed instrumentally, as in parents providing for their children's instrumental needs. Praise is also not forthcoming and parents are usually "satisfied, but you could have done better". Bulimics report that this results in their developing low self-esteem and high self-expectations.

The expression of emergency feelings in particular is masked. Negative feelings are displaced, "hinted at", covered by a "facade of serenity" or communicated by "cutting the person off emotionally" or detaching of self physically. Anger is "bottled up" and bickering and "snapping" about trivia prevails until there is an "explosion" where anger is expressed via acting-out behaviour - tantrums, tears sulking, screaming - "chaos".

All bulimics report that depression, hurt and sadness are not expressed openly and individuals hide away their "lack of coping" by physically with-drawing from other members.

It is possible that parents feel unable to deal adequately with emergency emotions as they attempt to "diffuse" these feelings or "jolly people out of them".

4.1.3.4 Roles

(i) Provision of Resources:

In all families there appears to be appropriate provision for material needs and no families evidence grave financial problems. However, in 2 families

(without father) where mother is the breadwinner, individuals describe only having essentials, no luxuries,"always wanting more".

In all intact families fathers are the breadwinners while 8 mothers are not employed outside the home. The financial contribution of 3 mothers who are employed is seen as providing extra money for luxuries.

All mothers bar one, appear to assume total responsibility for household issues, such as providing food, clothing and transport of children. In this one family, maternal grandmother who came to live with the family after father's death, has assumed responsibility for cooking.

(ii) Nurturance and Support:

In all families, mothers are perceived to be more available to the family than fathers, most of whom spend their time in work-related pursuits or in following interests of their own choice apart from the family. Mothers are thus seen as the central nurturing figure, whose "calm and inner strength" is perceived to "hold the family together and provide security and safety".

Nevertheless 8/13 bulimics express the desire for nurturance from their fathers, especially where mothers are perceived to be unable to give the support and nuturance desired. Bulimics seldom however seek nurturance from their fathers as they perceive them as having difficulty coping with emotions, especially negative emotions. They appear to make"token gestures" or withdraw.

Problems relating to mothers giving support appear to be as follows:

(a) Bulimics feel sensitive to mothers' feelings and try to protect them by

avoiding burdening them with their problems if they feel mothers are overburdened due to parental problems, or if they perceive mothers as being overly emotional and likely to become too involved in the issue;

(b) Mothers' ability to contain feelings. 8/13 bulimics describe their mothers as providing "matter of fact" comforting. These mothers are sometimes described as having difficulty tolerating negative emotions in their children and they become angry when children are upset, and indicate their desire to have their children coping by telling daughters to "pull themselves together" or by withdrawing and becoming "cold as ice" if they cannot handle the difficulty.

In 4 families where both parents are available, they often attempt to resolve the disharmony in their children quickly by giving "practical , "sensible , logical advice on how to cope emotionally".

(iii) Personal Development:

Mothers appear to be intimately involved in children's development and fathers are often excluded due to work preoccupation. Both or either parent attends to the children's education and there is an emphasis on academic achievement and being well-educated. Parents appear to have high ideals for their children although mothers are the ones involved in the daily actioning of these aspirations, supervising homework, having contact with school and providing transport for children to participate in extramural activities.

With regard to developing interests outside the home, children are often encouraged to participate in activities in which parents are interested. Thus where parents are interested in sport or creative pursuits, children are encouraged to participate in these activities. In families where

father has no outside interest or where father is dead and mother has no time for extra familial activities due to her work involvement, the children are not actively encouraged in social activities.

Half the bulimics suggest that parents are interested in hobbies in which achievement is possible so that children "cannot do things for fun" or that parents are "over-zealous, always wanting (them) to do more".

11/13 mothers appear to have few interests/activities of their own outside their homes, so that their homes are often their prime focus. Bulimics describe their mothers as enjoying "being a mother", with their prime aim being "to clothe and feed", although they realise that their mothers are unfulfilled and often "live through their children".

In half of all these families members are encouraged to share interests and do things together, for example, attending sisters' ballet concerts, watching brothers' cricket matches, attending brothers' music recitals.

Fathers are perceived to be the parent most closely involved in the outside world (their vocations) and they maintain their outside leisure pursuits

While sons are encouraged to participate in sport, daughters are most often encouraged to participate in traditionally feminine activities, such as ballet, music, domestic or creative pursuits.

With regard to teaching of social skills, 11/13 families appear to stress socially appropriate behaviour. One or other parent, or both parents, are often described as being "strict disciplinarians" and appear to stress conventional social norms, such as social graces, table manners and

etiquette, and children are often expected "never to put a foot wrong". In two families, one where mother is the breadwinner and the other where both parents work outside the home, there appears to be limited teaching of social skills.

9/13 mothers are reported to have assumed sole responsibility for sexual education of their daughters, "stressing", "watching" or accusing" and generally warning their daughters about sexual contact. Two bulimics who report that their fathers are "afraid" of their having sexual contact, reveal that their fathers have also participated in sex education. Two other individuals report having received no sex education and they relate this to mothers' difficulty in discussing this matter.

With regard to developmental issues, all individuals report that their parents have difficulty handling adolescent issues. Then, due to their somewhat overinvolved and controlling style, parents appear to have difficulty in handling the graded independence their children desire and this often results in covert conflict between the particular parent and the bulimic. Various patterns are described: mothers remain involved in their daughters' everyday lives although they reputedly understand their daughter's needs for independence; mothers pretend that it (adolescence) is not happening; parents expect socially appropriate adult behaviour as soon as the child reaches adolescence but they evidence difficulty in allowing their children to exercise their independence and to make their "own choice" about their lives.

Bulimics then complain that this results in their inability to cope with adult decisions once they leave home, their need for parents' approval, and feelings of insecurity and inadequacy when they attempt to establish an independent lifestyle.

(iv) Maintenance and Management of the Family System

Decision-making: While individuals describe various methods of family decision-making, responsibility for decision-making appears to rest with the parents. Although fathers are reported to be the head of the household, they often defer to mothers, saying "you know better", and mothers often "let" fathers have the final say. However, individuals are of the opinion that behind the scenes mothers are the policy makers.

Behaviour Control functions: Various methods of enforcing behavioural standards are employed, from inconsistent to "reasonable" to rigid disciplinary measures. The responsibility for behaviour control is mostly relegated to mothers because of their daily contact and involvement in their children's lives. Mothers maintain discipline by using "strong words", shouting, "exploding" and "spanking", usually when they are unable to tolerate "bad" behaviour any further, and they are often described as being "unreasonable", hitting in anger, and inconsistent.

Half the mothers also seem to threaten their children with father's discipline on his return from work.

Fathers, due to their professional lives, are not often involved, or only involved in more serious behavioural issues, and apparently reason with the child or explain why punishment is necessary. Half the bulimics report that mothers perceive fathers' attitudes as refusal to discipline and this engenders resentment and conflict between parents. In one family however where father disciplined via "aggressive outbursts", the mother disciplined by reasoning with the children "to prevent father's aggressive outbursts".

All individuals report that very early on familial rules are internalized so that by middle childhood very little erring occurs and that "a look", or the "fear of a reprimand" from parents is enough to maintain familial order.

Household finances: In all families, mothers deal with household finances and both parents deal with monthly bills. Fathers are responsible however for handling banking issues, income tax and other monetary transactions as they are the "head of the house" and breadwinner.

Health Related functions: Mothers assume responsibility for dealing with illness, health maintenance and health professionals. Interestingly enough however, none of the bulimic individuals told their mothers about their eating problems until a number of years had elapsed and these individuals were seeking professional assistance.

Where mothers had attempted to broach the issue, this was met with by denial and anger by the individuals so that in these 5 families the eating problem was a family secret- "everybody knew but nobody said".

Role Allocation: Assignment of roles in order to accomplish instrumental tasks appears to be explicit, with fathers assigning the role of home executive to mothers and mothers delegating tasks to children. All bulimics appear to feel that more discussion about delegation of tasks should occur but agree that assignment is not "unreasonable".

Assignment of function regarding the provision of nurturance and support appears to be implicit. 11/13 bulimics report that mothers are overburdened,

"always for children, nothing for self", often taking on responsibilities "which are not hers" while fathers are minimally involved. Where father is dead, mothers "try to play both parents". This situation appears to evoke guilt in these bulimics and they report attempting to nurture mother by providing companionship or becoming her confidante. While apparently encouraged by mothers in this role, they do not have the skills necessary to accomplish this task yet feel responsible as fathers do not assume this role.

Although half of these bulimics report being dissatisfied with this situation, this is not expressed in the family and instead the siblings and mother form a collaborative unit, while fathers apparently deny or avoid responsibility.

In the 3 broken families, despite the fact that mothers appear to be particularly overburdened, they do not encourage their children to nurture them and instead appear to struggle on alone, deriving satisfaction from being able to assume a dual-parent role. Bulimics in these families report that mothers' denial of the need for nurturance and support serves as a model for dealing with needs so that all individuals' needs remain unmet.

Role Accountability: 10/13 bulimics report that a sense of responsibility for tasks or functions is evoked out of a sense of fear of punishment from and guilt toward mother and that they feel bound to assume responsibilities. While mothers always check that instrumental tasks are completed, affective functions are ignored.

4.1.3.5 Affective Responsiveness

All families seem to evidence a limited ability to respond appropriately to welfare emotions (affection, warmth, tenderness, love, consolation,

happiness and joy). With regard to emergency emotions (anger, fear, loneliness, sadness, disappointment and depression) these are either severely restricted or overproduced.

10/13 bulimics describe their families as "intellectually" responding, rather than feeling. Families are described as "happy-go-lucky", "having no strong feelings" or having a "facade of calm and reason", everybody "hiding under a coping, strong, outside image".

All bulimics report an emotional constriction or neutrality in their families with regard to love, praise, joy and tenderness, although response to familial achievements appears to feature prominently.

Responsiveness to emergency feelings also appears to be characterized by constricted affect and is dealt with via denial or displacement in order to maintain a "reasonable" facade although the underlying atmosphere is often one of unresolved feelings, frustration and persistent tension. Because these negative feelings are unresolved, members displace them from one situation to another and from one person to another.

All bulimics report that appropriate response to these emotions is not sanctioned by their families as they are perceived to be potentially disruptive and members attempt to hide these emotions from others. While fear, sadness, disappointment, anxiety or depression is "dealt" with alone, anger cannot be ignored indefinitely. Instead, as angry feelings intensify, the family atmosphere is characterized by bickering, snapping or tension. Finally, when anger can no longer be contained, it is often of a highly excessive amount, poorly controlled and / or integrated, often situationally inappropriate and acted out. This overproduction of emotion appears to reinforce the families' fear of expressing anger so that attempts are made to keep aggressive feelings under control at all times.

4.1.3.6 Affective Involvement

The central characterizing feature of all these families is the family ethic: the belief in the maintenance of the family as a unit, of family "togetherness" and of the family as a place where all needs can be met. This is emphasized by fathers in intact families and mothers in broken families. This ethic manifests itself in various ways: the parent encourages intrafamilial contact and discourages extra-familial contact; the pursuit of interests and activities as a family is encouraged, while individual interests are often disregarded; siblings are encouraged to maintain their sibling ties socially; children are often actively discouraged from leaving the parental home.

All bulimics report that independent development is restricted and that they are not allowed "space to be different".

Parents are perceived as "forcing ideas on" or "pressurizing" the individual, often trying to maintain responsibility for their daughters' decision-making in adolescence. This overinvolvement is however perceived as being "better than no concern at all".

This ethic of affective involvement is espoused by all family members and mothers are perceived to be the central figures, holding the family together. In reality, the experience of family members often appears to be that of a family involved at an instrumental level, with members narcissistically involved in the family, that is, concern for other family members appears to be secondary to the concern felt for self. Hence the family experience is one of "instrumental togetherness" and is somewhat barren of real empathic involvement.

Despite the fact that bulimics report limited emotional involvement between family members, the family ethic of the importance of a highly involved and invested family is adhered to.

This ethic appears to be given credence and is reinforced by the apparent presence of an overinvolved dyad in the family, the bulimic and her mother. All bulimics describe a highly ambivalent overinvolved relationship between their mothers and themselves and this was observed to be the case even where the negative aspects of one individual's relationship with her mother appeared to obscure their overinvolvement and the bulimic's dependency, due to her perception of an elder sibling as having the desired exclusively positive relationship with mother.

This overinvolvement appears to manifest itself at an instrumental level. Mothers are described as "trying to live life through their children", "pouring" themselves into the family, "being everything - more than a mother", and giving "half her life to making mine work". However, all bulimics acknowledge their ambivalent stance toward their mothers, for while criticising her for being interfering, overprotective and controlling, they hint at their desire to have her "in, but ...... out", "distanced, but ......close".

This overinvolved dyad is not without price however and curiously while subscribing to the family ethic, other members become isolated: fathers retreat further into their professional roles or solitary leisure pursuits; sibling rivalry often arises between the bulimic and other siblings; and these siblings often form subsystem sibling dyads or detach themselves from the family, seeking nurturance outside the family.

But, while no member is nurtured, no member challenges the system.

4.1.3.7 Behaviour Control

In all families it appears that clear standards for the behaviour of members exists. While these rules are made explicit in childhood, by the time individuals reach puberty these standards are implicit and entrenched. All bulimics report that family members' behaviour is monitored and regulated by the family ethic, which is internalized at an early age and transgressions are few as "your conscience tells you are transgressing".

Standards for behaviour with regard to physically dangerous situations, the expression of particular psychobiological needs and drives, and social situations appear to be clear to all members:

(i) Physical danger: All bulimics report adequate or even overconcern for the physical safety of members, with parents or siblings often accompanying one another outside the home; parents prefering their children to remain at home, rather than sleeping over at friends "because she (mother) worried about us".

(ii) Psychobiological needs and drives:

Eating: All families appear to uphold rigid standards with regard to eating, at least until children reach high school. All bulimics describe parents' desire for ritual eating together as a family, and it is often here that "family conferences" with regard to familial issues are held and where the atmosphere is often one of underlying tension or superficiality, in an attempt to avoid discussion of emotionally laden issues. It appears that many mothers expect everyone to eat what is served, "even if you hate it" and some report "never being allowed to say you have had enough". Both parents, but fathers in particular, appear to uphold stringent standards for table manners, and comments during the meal on appropriate table manners are often a daily experience. The practice of eating together appears to change once siblings reach high school. Various reasons are given: participation in extra-mural activities by various members means a disturbance of family patterns, which are not flexible enough to accommodate this change, and so fall away; mothers or siblings express a desire to diet, which means a disturbance of family patterns, so that family members devise a method of eating when "convenient" or alone; overt conflict erupting during the family's eating reinforces the family's desire to eat separately.

Sleeping: Although all families appear to uphold rules with regard to bedtime, these are not stressed. Sleeping arrangements vary and no clear trend is noticeable.

Hygiene: The majority of individuals (9/13) stress that rigid standards for cleanliness or neatness are upheld, although either parent is involved. Fathers in particular are described as "obsessional" with regard to standards of hygiene.

Sexuality: The majority of individuals (11/13) report having received sex education and that mothers repeatedly warn against indiscriminate sexual contact. Fathers are also reported to fear sexual contact for their daughters and bulimics often report being denied what they consider appropriate contact with the opposite sex in early adolescence.

Aggression: There appear to be no clear rules for handling aggression. While its expression is not sanctioned and the family model of coping is via denial, aggression is often expressed via acting out behaviour. All bulimics report a resultant difficulty with the appropriate recognition and expression of anger.

(iii) Social behaviour: In the families where parents are socially active, socially appropriate behaviour is stressed and social etiquette appears to be of primary importance to parents, particularly mothers, and individuals indicate that parents set an example by their social behaviour.

Standards stressed appear to relate to respect for authority figures, for example, parents, and "being nice and polite to others". 7/13 bulimics report suspecting that it is important to their mothers that they behave appropriately, as mothers perceive their children's behaviour as reflecting their child-rearing capabilities. While this behaviour is stressed for extra-familial social situations, this behaviour is often not practised in the families so that a discrepancy arises as to what is acceptable social behaviour, as opposed to an "anything goes" attitude toward private behaviour. Whereas clear standards for extra-familial social behaviour exist, 11/13 bulimics report that family interactions are governed by implicit rules. They report that parents appear to be more concerned with eliciting societal approval than instilling appropriate behavioural standards in their children.

In contrast, in families where parents have little social interpersonal contact, no social standards are stressed. Bulimics instead report having to adopt their own standards and feeling socially inept because no family role models are available, as well as lacking appropriate behavioural standards and internal controls.

The style of behavioural control in all these families appears to be that of chaotic control. Two patterns are described:

(i) 8/13 bulimics describe behavioural standards as rigid and parents as flexible, so that rules are imposed with little or no negotiation. They state that consequences are known and that parents agree on rules. However, because of problems between parents with regard to backing each other up and/or differences in their discipline techniques, some manipulation of the more lenient parent, usually mother, is possible.

(ii) 5/13 bulimics describe behavioural standards overall as flexible, reasonable and negotiable. However, due to parents' inconsistent enforcement of these standards, consequences vary and parents' disagreement regarding the implementation of rules means that they can be manipulated.

While many of these standards appear to be appropriate in preadolescence these standards are inappropriate once the child reaches adolescence. In these families it seems clear that change is not easily introduced so that young adolescents feel restricted. It is at this stage that bulimics report most conflict occuring: between parents, when one parent is aware that a change of focus is needed and attempts to allow the children to negotiate their own standards, while the other attempts to maintain the old patterns; in broken families, the single parent attempts to maintain the old patterns

despite the changing needs of the children; between the children and parents - while siblings are reported to be able to challenge parents' standards, bulimics often report feeling the urge to rebel, yet being unable to do so. Instead they appear to carry these conflicting feelings within them but do not express them.

The above dimensions of the McMaster Model of Family Functioning have detailed the family structure, organization and transactional patterns of the families of bulimics.

The following section will incorporate the above discussion in an assessment of the families' ability to deal with the various tasks deemed to be of importance in the development of the individual; namely basic tasks, developmental tasks and hazardous tasks (Epstein and Bishop, 1981).

4.2 DISCUSSION

4.2.1 Family Functioning

4.2.1.1 Basic tasks

What is striking in these families is that all tasks that are instrumental and fundamental in nature, such as the provision of food, money, transportation and shelter are successfully dealt with. Fathers are the traditional breadwinners while mothers are the home executives in charge of household management. Apart from providing finance however, fathers participate very little in the family process. They are often overinvolved in the extra-familial world and mothers often assume a dual-parent role. It seems likely that mothers, overburdened in their roles, will have little time or energy for dealing with

affective development, so that instrumental functioning remains the focus.

A high investment in"coping" appears to exist in these families, so that parents attempt to deal with all instrumental issues and crises before they impinge on family functioning. This seems to result in a model of family functioning where instrumental coping is highly valued, as is smooth functioning of the family.

4.2.1.2 Developmental tasks

This is an area in which the difference between these families' instrumental coping ability and their ability to provide for the adequate development of their members is most evident.

All these families appear to be deficient in their ability to provide an environment in which the social,psychological and biological development of their members is balanced. All interactions appear to occur at a practical, instrumental level, where socially appropriate behaviour is stressed, whereas affective development is neglected. Whereas these families appear to deal successfully with instrumental issues, the existence of affective issues is denied so that their appropriate resolution is precluded. It seems that in these families with a high investment in "coping", affect is perceived to be "irrational", uncontrollable and potentially threatening, so that families reveal an affective restriction. Members maintain a facade of coping so that no revelation of self or feeling occurs. Emergency emotions or conflict are thus dealt with via denial or displacement onto instrumental issues, so that conflict is expressed in the realm of instrumental issues. Affective issues nevertheless remain, unresolved, leading to an increase in tension in the family. Ongoing attempts are made to diffuse and control anger, for

example, until eventually anger cannot be contained and is overproduced via acting-out behaviour (loss of control).

This overproduction however, appears to serve as reinforcement for attempts to control anger again and the cycle is repeated. Affect also appears to be restricted with regard to welfare emotions, so that nurturance and support are expressed in an intellectual manner or instrumentally. A possible reason for this appears to be fathers' overinvolvement in the extra-familial world, often to the exclusion of the family process. Mothers are often overburdened as they have full responsibility for household management as well as nurturance, while receiving little or no help from fathers who are cited as adopting a "logical" approach to life. It may be that mothers lack the time or energy to deal with affective issues appropriately and that they are thus threatened by their childrens' inability to cope, perceiving this as an accusation against their own coping ability or child rearing ability. They may attempt to deal with these potentially disruptive issues in an immediate, practical manner. The bulimics then cannot turn to their fathers for support, either because of their absence or because of their attitude to affective issues. Thus feelings remain unresolved. It is also likely that individuals then learn to deal with needs for love and the expression of negative affect in an instrumental manner.

An area of significance in these families appears to be the area of food and eating. Mothers who are perceived to be the central nurturing figure appear to make the home and the provision of food their prime focus. However, food may be divested of its symbolic nurturing qualities, since much of the interactions centred around the feeding process are instrumental in nature with the focus often on ritual eating together, family discussion of instrumental issues and socially appropriate table etiquette.

This feeding process may also become associated with anxiety and negative affect for these individuals since it often occurs within an atmosphere of underlying tension due to these families' efforts to keep interaction at a superficial level in order to avoid conflict.

As was previously mentioned, there is a high degree of investment in maintaining a facade of coping, family unity and family solidarity. It seems likely that in order to maintain such a family unit however, a rigid style of control over members' behaviour is necessary. In these families standards for behaviour appear to be clear although the behaviour control in evidence may be somewhat chaotic, fluctuating between rigid control and loss of control. Rigid control over individuals' behaviour may lead to covert rebellion in the children. Parental disagreement over control measures means, however, that individuals are able to manipulate either parent so that controls are withdrawn entirely or partially. Inconsistent reinforcement of standards may lead to irritation and anger which is supressed and controlled. Supressed anger appears to erupt in angry outbursts. This overproduction of anger (loss of control) may reinforce these families' desire to control anger again. Suppression of anger then leads to an eruption again and the cycle is continued.

Control of another kind may also be exercised by mothers, who in making their homes their prime focus, appear to become overinvolved in their children's lives. This overinvolvement however, appears to manifest itself at an instrumental level, with mothers attempting to live vicariously through their children's activities.

In families such as these, with their strong focus on maintenance of the family system, it seems likely that they will experience difficulty negotiating exchange of control, which is a necessary transition associated with adolescence

in the family life cycle. It may be that in families such as these, where affective issues are perceived to be potentially threatening to family unity and thus denied, adolescent issues, such as strivings for individuation and sexuality, will also be denied. Parents may attempt to maintain the family system as is, by reinforcing their control over their children's lives, while mothers may remain overinvolved instead of allowing a gradual shift of control. At this stage the pattern of control which vacillates between rigid control and loss of control may intensify as parents and children battle for control, although the degree of rigidity maintained and flexibility attained may differ from family to family.

4.2.1.3 Hazardous tasks

Due to these families' needs to maintain the status quo, in times of crises that arise in association with critical experiences such as illness, or moves of job, home or country, it is likely that these families will have great difficulty relinquishing their accustomed patterns of behaviour.
Extra-familial stress may require adaptations that families such as these cannot make.

It seems likely that families, particularly parents, deal with these tasks at an instrumental level, while failing to acknowledge or appropriately deal with the affective components of these tasks, such as anxiety, fear or disappointment.

Thus the pattern of coping with critical experiences is established: critical tasks are dealt with at an instrumental level while associated negative affect is denied, thus engendering a feeling of control and coping.

In the final chapter, the development of bulimia from a systems perspective will be proposed. The family functioning of the families of bulimics will be compared with the families of anorexics; methodological issues as well as directions for future research will also be presented and conclusions drawn on the overall value of this study and its contribution to the field of knowledge on bulimia.

CHAPTER FIVE

FAMILIES OF EATING DISORDERS: EVALUATION AND CONCLUSIONS

5.1 Introduction 138

5.2 Methodological issues 140

5.3 Bulimia: a systems perspective 145

5.4 Family functioning in bulimia and anorexia nervosa 147

5.4.1 Qualitative data 147

5.4.1.1 Problem solving 147

5.4.1.2 Communication 148

5.4.1.3 Roles 149

5.4.1.4 Affective responsiveness 149

5.4.1.5 Affective involvement 150

5.4.1.6 Behaviour control 151

5.4.2 Quantitative data 152

5.5 Summary and conclusions 153

CHAPTER FIVE

FAMILIES OF EATING DISORDERS: EVALUATION AND CONCLUSIONS

5.1 INTRODUCTION

Bulimia, according to the literature, appears to be a syndrome which occurs mainly in young adult women (the most common age range being 18 - 24 years) rather than in adolescents, as is the case with anorexia nervosa (most common age range being 14 - 17 years) (Section 1.3.1). This was not, however, the finding in this study, nor that in a recent prevalence study conducted in Cape Town (Robinson, personal communication), where the age range was found to differ widely. Onset of bulimia often appeared to occur in early adolescence (13 years), while these individuals are living at home with their parents; in late adolescence; as well as in the mid-twenties, several years after individuals have left home. However, it appears that attempts to diet and development of body preoccupation in all these individuals seem to have begun in early adolescence and continued until the onset of bulimic symptoms. Thus in some individuals an episode of anorexia nervosa may have preceded the onset of bulimia (Section 1.2).

The varying age of onset of bulimia alone mitigates against our being able to explain bulimia from the systems perspectives employed in anorexia nervosa (Section 2.6.2) where symptoms arise within the context of the family and are maintained by the individual's participation in the family process. In the case of many bulimics, symptoms often arise after they have left the family and are in fact maintained sans famille.

What is clear however, is that the disorder appears to be precipitated by a change of some sort, for example loss or separation from significant

figures, change in school, occupation or residence, or the beginning or termination of a sexual relationship, which results in the individual struggling to deal with feelings of inadequacy, insecurity, or sexuality. (Section 1.3.2).

How then can a systems approach explain the development of bulimia?

The family certainly play a role in the individual's development, providing an environment in which the social, psychological and biological development of the individual occurs (Epstein, Levin and Bishop, in Gurman and Kniskern, 1981). Thus in these families it is important to investigate and describe the environment in which the individuals develop. As has been shown the functioning of these families is unhealthy (section 4.1.2).

Current data also appears to suggest that bulimics evidence several personality and behavioural deficits (Section 1.3.7). Thus it seems that within these families, family functioning is impaired enough to produce individuals whose psychological development is markedly impaired.

But why a particular individual and why bulimia?
As Norris and Jones (1979) state, the reasons why one family member rather than another becomes symptomatic have not been definitively settled, and the reason why particular symptoms rather than others develop is unclear.
This thesis would thus contend, as do Norris and Jones (1979) in their hypothetical model of anorexia nervosa, that bulimia represents a "compromise solution of conflicting structures and processes operating on the one hand on the child as a component of the family system and on the other hand from within the child as a subsystem herself" (p 109) and that both "internal" and "external" properties must coexist for bulimia specifically to arise.

Although this thesis attempts to describe the processes within the family in which the bulimic participates, it is not within the scope of this thesis to examine possible intrapsychic or genetic processes within the particular individual which may predispose her to the development of bulimia. Instead, simply stated, the standpoint in this thesis is that bulimia represents the bulimic individual's "solution" to the forces within her which are in conflict with the family process.

This chapter will present a hypothetical model of the development of bulimia from a systems perspective. However, it is necessary to review methodological issues which must be considered in the interpretation of the results.

5.2 METHODOLOGICAL ISSUES

As many of these issues have been dealt with fully in the preceding text, they will be dealt with briefly at this point. Further methodological issues will also be raised.

(i) Subjects. As has been noted (p 10), the broadness of the DSM - III criteria potentially allows a very heterogenous set of people to be included in the research. Although the subjects in this study represented a standardized sample in that all individuals exhibited all symptoms designated by the DSM - III as being symptomatic of bulimia, differences in symptom frequency were not considered. It is possible that such differences may imply other differences in the individuals or their families. However, in this study despite wide ranges in symptom frequency in bulimics, all families were assessed to be unhealthy on all dimensions of family functioning (see section 4.1.2.2). This seems to suggest that at least in the present study symptom frequency did not

affect the results, but perhaps the measures used to assess family functioning were too coarse to detect such differences. Further research in this area is obviously needed.

Individuals who are members of "eating disordered" subgroups were included in the sample (for example, ballet dancers). While it has been suggested that these individuals may not in fact be "true" bulimics, this did not appear to be the case for these subjects (see p 79). In addition, these individuals' families did not appear to evidence differences from the other families in the study, as assessed by the FAD. The possibility cannot be excluded however, since the FAD is merely a screening instrument for dysfunction and a fuller investigation into this issue is needed.

Individuals represent a mixed group with respect to their treatment histories and family knowledge of the problem. This issue was dealt with on pp82-83. Neither of these issues appears to have played a significant role in the family members' perceptions of their families as no clear trend emerged with regard to family ratings. However, with a bigger sample, clear trends may emerge and further investigation is needed in this area.

It is acknowledged that the subjects included in this research represent a mixed group of individuals and this may have confounded the results. As this study is of an exploratory nature however, heterogeneity was considered permissible. Further research needs however to address this issue - where homogeneity of sample is achieved in order to confirm these results.

(ii) Sample size. The small sample used means that the descriptions of these families cannot be generalized to describe bulimics as a group. However, if this study is viewed as an exploratory study, the clear trends observed should provide a strong impetus for further work in this area. In addition, the self-selected nature of the population means that the findings relate to individuals and their families who are prepared to

reveal themselves. Where parents are aware that their daughters have an eating problem, it may be that these families are invested in revealing themselves as healthier than they are, and these families' responses may well be open to perceived demand effects (Orne, 1962).

(iii) The posing of the research question. It is also not known how bulimics framed the research question to their parents, whether family members followed instructions and how willing these family members were to participate in the research process, since the researcher had no contact with these families. This may also have resulted in differences in the various family members' perceptions.

(iv) The retrospective nature of the study. This was fully dealt with in the section on Methodology (section 3.2.1). In addition however, as the family members were requested to assess varying periods of time, it may be that family members chose varying points in time to be a reflection of family functioning and these may not reflect the overall ethos of the family. Several members also commented that their data may be retrospectively distorted due to the passage of time. For example, in one individual whose symptom duration was 12 years, family members had to disregard these past 12 years and then attempt to assess family functioning in the preceding 15 years. In this case, data would almost certainly be distorted, despite the fact that these members' ratings, like all other participants in the study, reflect unhealthy family functioning.

It also seems clear that family functioning undergoes developmental changes as the members mature. It was in fact suggested by family members that the FAD does not adequately cover all phases of the family development and that it is very difficult to give "overall" ratings. Thus the ratings eventually given may again reflect varying points in time.

The above issues may account for the fact that various family members rated differing numbers of unhealthy items on the FAD, resulting in differing scores and differing levels of diagnostic confidence with which one may predict dysfunction (Table 5). However, as Epstein and Bishop (1983) note, it may simply be that the family members hold different perceptions of their families, although the results seem to indicate that ratings differ with respect to degree of unhealth rather than absence or presence of unhealth.

(v) The fact that a questionnaire was employed to elicit individuals' perceptions of family functioning means that the results are open to all the criticisms reviewed in section 3.2.2. An example of possible distortion of data was evident in the specific response styles of the various family members particularly fathers who appeared to mark all statements either 'Agree' or 'Disagree', and the extremes of 'Strongly Disagree' or 'Strongly Agree' were seldom contemplated, whereas bulimics more often marked the two extremes.

(vi) Possible limitations of the McMaster Model. The dimension of Affective Involvement appears to be open to a form of faking. In families such as these, with their high investment in family unity and closeness, and to a large extent perceiving this as appropriate, the FAD questions did not appear to elicit the family pathology. This is borne out by the fact that bulimics when providing the qualitative data upon which the researcher's assessment is based, described their families as "selfish", their mothers as "too involved" and their fathers and siblings as "there but not there". However, an item analysis of FAD results on this dimension reveals a marked difference between the researcher's assessment and bulimics' ratings, suggesting that the FAD items on the Affective Involvement dimension may not elicit family pathology in this area. For example, bulimics disagree with the

following statements:

(Item 5) If someone is in trouble, others become too involved.

(Item 13) You only get the interest of others when something is important to them.

(Item 25) We are too self-centred.

(Item 54) Even though we mean well, we intrude too much in each others' lives.

(vii) Qualitative data based on the bulimics' perceptions. This issue was fully dealt with in section 3.2.2. While it seems likely that the bulimics' perceptions may well reflect a realistic account of family functioning, the fact that only one member's perceptions in each family account for the qualitative data, means that the findings in this study need to be regarded with circumspection. Further research which would include family interviews with all family members participating, is needed in order to confirm these findings.

(viii) In the concluding section of this chapter, family characteristics of the families of anorexics, obtained from the literature are compared with the data obtained in the present study of the families of bulimics. It should be remembered however, that the conclusions drawn are tentative since research methods to obtain these data differ as do the theoretical standpoints of the researchers. This applies even where the findings have been obtained via family interviews using a systems approach, for example, the findings of Palazzoli and Minuchin. As these comparisons represent an adjunct to the main thrust of this thesis, which is an exploratory

study into the families of bulimics, it is felt that an indepth exploration of discrepancies in methodology is not within the scope of this thesis. Thus findings in this regard should be seen as tentative and further research is necessary to validate these trends.

(ix) The fact that a control group of "normals" and/or anorexics and their families was not used means that the specificity of the family pathology cannot be assessed, so that findings and comparisons made must be seen as tentative and thus considered as pilot data.

5.3 BULIMIA: A SYSTEMS PERSPECTIVE

Given the pattern of dealing with affective issues as well as the pattern of maintaining control in these families, it is likely that bulimic individuals will attempt to deal with the changes associated with adolescence in a similar manner. Given the instrumental focus in these families, the adolescents' attempts to control disturbing inner strivings may be played out in a practical manner by gaining control over the body. Rigid control over the body may therefore manifest itself in attempts at dieting and limiting of food intake. This method may be reinforced by the fact that food for these individuals may be associated with anxiety, tension and negative effect. Thus individuals may feel that they have established a sense of control over their lives, albeit a precarious one.

This sense of control established by these individuals may reinforce attempts to deal with other anxiety-producing situations associated with individuation and/or sexuality, via body control and limitation of food intake. This also appears to reinforce the families' pattern of dealing

with crises as well as affect. However, an increase in anxiety or other negative affect may result in the individual being unable to control these feelings, which results in an outburst in which there is a loss of control over food intake (binge). Intake of food, associated with anxiety and negative affect as well as guilt and fear, may result in immediate attempts to rid the body of food (vomiting and purging), while at other times attempts may be made to reinstitute rigid control over further food intake via severely restrictive diets. In this way, a cycle may be established for coping with threatening affect - attempts at rigid control (dieting), eventual loss of control (bingeing), attempts to reintroduce a measure of control (vomiting and purging) and reinstitution of rigid control.

The question now arises as to how bulimia is both maintained by, and maintaining of, the system.

Bulimia is often called "the secretive syndrome", a term coined by Herzog (1982), as its presence is not usually obvious to individuals other than the bulimic, as the binge/purge/vomit/starve cycle is usually conducted in secret. This means that these individuals develop a method of coping with undesirable feelings which does not disrupt the family system, an ethic of great import in these families.

Individuals report feeling unable to reveal their "secret" to other family members as "there would be chaos" or because "it would hurt them". Paradoxically, the very "secret" which would ostensibly cause "chaos", should it be revealed, is indicative of the chaos existing in these families. Rather than hurting their families, they instead inflict pain on themselves and keep their secret. However, the expression of these symptoms by these individuals may in fact be an expression, in a masked and indirect manner, (the method of communication in these families) of these families' functioning.

In addition, the individual continues to appear to cope at an instrumental level, a fact which is no doubt pleasing to her family. This fact in itself is reinforcing of the disorder, since the individual manages in this way to maintain the approval of her parents while developing some measure of "control" over her life.

Thus the model of family functioning and the patterns of control established in these families serve not only to maintain the bulimic symptoms while the individual remains in her family, but also serves to explain why this disorder may develop and be maintained long after the individual has left the family system. There is no other way of coping.

5.4 FAMILY FUNCTIONING IN BULIMIA AND ANOREXIA NERVOSA

There appears to be a marked similarity in the family functioning of families of bulimics and anorexics as detailed by systems theorists such as Crisp (1980); Palazzoli (1974); Minuchin et al (1978) and Norris and Jones (1979)(Sections 2.6.2.1 - 2.6.2.5). However there are subtle differences which appear to have implications for aetiology and management. It is highly likely that researchers who have tended to regard these groups as homogenous, given the marked similarity of functioning, have tended to overlook these differences, which appear to play a role in the symptom formation, as suggested by Adamson (1984).

5.4.1 Qualitative data

5.4.1.1 Problem Solving

It is well documented that the families of anorexics value harmony and peace and that their threshold for conflict is low. Thus they appear to maintain

a rigid control over conflict and when conflict erupts, rigid control is again instituted so that problems remain unresolved (Minuchin et al, 1978; Norris and Jones, 1979; Garfinkel et al, 1983).

While the families of bulimics also attempt to maintain a rigid control over conflict, when conflict erupts, there is an overproduction of anger (loss of control) so that problems remain unresolved. It seems likely that this pattern of behaviour also occurs in the families of anorexics with bulimic features.Strober's (1981) quantitative data reveals that there are higher levels of conflictual interactions in these families than in the families of restricter anorexics.

5.4.1.2 Communication

Disturbances in the communication of the families of anorexics has been documented by Palazzoli (1974) and Garfinkel et al (1983).

In general, there are a great deal of communications which are rejected or disconfirmed in the families of anorexics, but whereas the communication style in the families of restricter anorexics appears to be clear, in the families of anorexics with bulimic features it is masked (Palazzoli, 1974).

The latter style is also apparent in the families of bulimics. Intended messages are obscured and there is a contradiction in non-verbal and verbal messages.

While Palazzoli (1974) suggests that anorexics' rejection of food is symbolic of the interactional style in their families, from this perspective bulimics' ambivalent behaviour toward food appears to be expressive of their families' interactional style.

5.4.1.3 Roles

It has been suggested that the parents of anorexics do not assume appropriate responsibility for systems management (Palazzoli, 1974). It may be that in this situation, the anorexic attempts to take responsibility for and control of the system, for both Crisp (1980) and Norris and Jones (1979) have noted that anorexics and parents often compete for the adult role positions.

In the families of bulimics however, it is clear that parents, or at least mothers, appear to assume total responsibility for the system management so that bulimics are denied the opportunity of learning to take responsibility for themselves.

Individual development appears to be denied to both anorexics and bulimics as it seems that in these families parents attempt to live through their children, encouraging them to achieve the parental ideals and fantasies and to value family ideals and values above autonomy (Crisp, 1980).

5.4.1.4 Affective Responsiveness

In both the families of bulimics and anorexics there appears to be an affective restriction, particularly with regard to aggression (Norris and Jones, 1979). In the families of anorexics, particularly the families of restricter anorexics, eruption of aggression appears to be subject to more rigid control than in the families of bulimics and those of anorexics with bulimic features, where anger is overproduced (Strober, 1981).

Thus a pattern of vacillation between attempts at rigid control and ultimate loss of control over anger seems probable in both the latter families.

5.4.1.5 Affective Involvement

Both the families of bulimics and anorexics appear to value family unity, loyalty, closeness and internal involvement over autonomy so that individuals learn to subordinate themselves to family needs (Norris and Jones, 1979; Minuchin et al, 1978; Kalucy et al, 1977). Strober's (1981) quantitative data indicated however that within the families of restricter anorexics there is more cohesiveness, mutual support and concern than in the families of anorexics with bulimic features, where these anorexics appear to be more distant and alienated from their parents, although the degree of distance and alienation evidenced is unclear.

What does seem likely is that the degree of overinvolvement between parent(s) and child in the families of anorexics (Kalucy et al, 1977; Norris and Jones, 1979; Minuchin et al, 1978) may be greater than in the families of bulimics, as suggested by the present study.

In both the families of bulimics and anorexics, mothers have been cited as being the central nurturant figure (Norris and Jones, 1979). While it has been suggested that anorexics engage in competitive mothering behaviour (Norris and Jones, 1979), the present study suggests that bulimics appear to be more likely to be cooperative, attempting to help mother to fulfill her role.

Most systems formulations appear to focus on the role of the anorexic in the avoidance of parental conflict (Palazzoli, 1974; Minuchin et al, 1974; Crisp, 1980) although this hypothesis has been widely criticised (Yager, 1982).

While there appears to be some similarity between Crisp's (1980) description

of the families of anorexics as "pseudo-families" and the present study's findings of the facade of affective involvement in the families of bulimics, it is not altogether clear from the present study how bulimics may serve as "avoidance circuits" for parental conflict, as anorexics are reported to.

While it seems likely that marital relationships in the families of bulimics are not what they purport to be, in view of the present study's findings it is suggested that bulimics may attempt to take on the role of fathers, in their attempt to nurture mothers. It may be that they thus aspire to a masculine self-ideal (Rost et al, 1982) and the development of symptoms may reflect their ambivalence toward a traditionally feminine role, as suggested by Boskind-Lodahl (1976) and Boskind-Lodahl and White (1978).

No clearcut statements can be made however since the data on the families of bulimics is exploratory. Nevertheless it is clear that further investigation in this area is necessary.

5.4.1.6 Behaviour Control

In both the families of anorexics and bulimics there appears to be an over-concern for the behaviour and psychobiological needs of the members, and an over-focusing on the need to maintain socially appropriate behaviour and appearances. (Minuchin et al, 1978).

Both groups appear to experience difficulty with adapting to change and relinquishing their accustomed patterns of behaviour.

While the families of anorexics, particularly restricter anorexics, appear to maintain a rigid control over members' behaviour (Strober, 1981), in the families of bulimics the pattern of control appears to vacillate between

attempts at rigid control and withdrawal or loss of control. There is also the suggestion that this may also be the pattern of control in the families of anorexics with bulimic features (Strober, 1981).

It seems likely that at adolescence, these patterns may intensify as parents and children battle for control.

5.4.2 Quantitative data

From a quantitative perspective, whereas the families of anorexics "approach" the level for unhealthy functioning on only four dimensions: Task Accomplishment (the definition of which coincides with the Problem Solving dimension); Communication; Role Performance(the definition of which coincides with the Roles dimension), and Affective Expression (the definition of which coincides with the Affective Responsiveness dimension) (Garfinkel et al, 1983), the present study indicates that the families of bulimics evidence unhealthy functioning on all dimensions. This seems to suggest that bulimic individuals tend to develop in family systems in which there is greater disturbance than is found in the families of anorexics.

In addition, as in the families of anorexics (Garfinkel et al, 1983), mothers and bulimics also evidenced higher scores in their endorsement of unhealthy items, indicating unhealthy functioning, than do fathers (Table 5).

A difference is, however, evident in the fathers' ratings. Whereas the fathers of anorexics did not rate their families as experiencing increased difficulties on any dimension (Garfinkel et al, 1983), the fathers of bulimics, although endorsing fewer unhealthy items than mothers and bulimics, nevertheless rated their family functioning as unhealthy (Table 5).

However, due to the limited information available on the instrument used by Garfinkel et al (1983) in their study, limited conclusions can be drawn. It seems likely, however, that in both sets of families, fathers appear to perceive "less" disturbance than mothers and their anorexic or bulimic daughters. This may well be due to the fathers' disengagement from the family process and their consequent lack of awareness of family processes, but it is equally possible that fathers may have a higher investment in presenting their families as healthier than they really are. Another possibility, of course, is that their perceptions simply differ. It is suggested that further investigation and research is necessary in order to answer these questions.

A further interesting finding is that the present study indicates that the family interactions of the families of bulimics appear to be similar to those in the families of anorexics with bulimic features,as documented by Strober (1981), while clear differences are observed between these sets of families and the families of restricter anorexics (Strober, 1981).

Although these findings cannot be generalized, due to the preliminary nature of the data available on both the families of bulimics and anorexics with bulimic features as well as the different methodologies employed, these findings raise an interesting issue which will be dealt with in the concluding section.

5.5 SUMMARY AND CONCLUSIONS

The common finding, with regard to both sets of families, is that they fail

to prepare the adolescent to cope with adolescence (Crisp, 1980; Minuchin et al, 1978; Palazzoli, 1974; Norris and Jones, 1979) and in the case of bulimics, to deal with further stressful changes.

It seems that in all these families, adolescent strivings for individuation and sexuality are denied as parents attempt to rigidly maintain preadolescent family patterns of behaviour and control. It seems likely that food/body issues then become the focus, the area in which these individuals attempt to assert their independence and self-control, in a manner expressive of the family patterns of control.

While it seems clear that both sets of families evidence difficulties on all dimensions, at a quantitative level the difference appears to be one of degree, while at a qualitative level the difference appears to be in the patterns of control in the family and the expression thereof.

While the pattern of control of behaviour and negative affect in the families of anorexics appears to be characterized by rigid control, the pattern of control in the families of bulimics appears to alternate between rigid control and withdrawal or loss of control. In view of the rigidity of family patterns which are maintained in these families, it is hypothesized that anorexics express their self-control via body control in a consistently rigid manner, by limiting their food intake indefinitely.

Bulimics on the other hand seem to attempt control of self and negative affect via body control in a manner which alternates between attempts at rigid control (limiting food intake), loss of control (bingeing) and attempts to reinstitute control (limiting food intake, vomiting and/or purging).

The families of bulimics also appear to evidence a greater degree of unhealthy functioning than the families of anorexics, which may provide some basis for

the postulation that bulimic individuals are likely to be more seriously disturbed than anorexic individuals.

The apparent similarities between the families of bulimics (in the present study) and anorexics with bulimic features (in previous studies, sections 2.6.2.1 - 2.6.2.5) raises an interesting issue.

In Section 1.2 it was made clear that several researchers argue for the heterogeneity of anorexia nervosa as a syndrome, regarding bulimic symptoms as a distinct subgroup, while others suggest that bulimia can occur as a syndrome apart from anorexia nervosa. The DSM-III (APA,1980) attempts to delineate clearly two separate syndromes in anorexia nervosa and bulimia, and although stating that the two syndromes are mutually exclusive, does not provide diagnostic criteria which provide us with "a model of clearly defined mutually exclusive and collectively exhaustive categories each with its own name" (Swartz, 1982, p 26).

It is tentatively suggested that a different perception may serve to clarify the existing classificatory difficulties in this area. In view of the differences suggested between the families of restricter anorexics on the one hand and the families of bulimics and anorexics with bulimic features on the other, and the similarities suggested between the families of bulimics and the families of anorexics with bulimic features, it may be that there is more commonality between the two latter groups than is generally acknowledged. In addition, in view of the similarity of symptoms in these latter groups (binge/purge/vomit/starve cycle), the question is raised as to whether all individuals manifesting these symptoms should not be regarded as bulimic, irrespective of weight.

While it is acknowledged that further research is necessary before these questions can be answered, it is suggested that such a view would have

implications not only for our understanding of the disorder but also for management, as suggested by Herzog(1982).

Both anorexics with bulimic features and bulimics are generally seen as having a poorer prognosis than retricter anorexics (Section 1.6). In view of the findings in this present study and the suggested similarity between the former groups, it is suggested that a shift of focus is needed in the understanding and treatment of these groups.

It is well documented that individuals with bulimic symptoms,and their families, are often regarded as exhibiting "anorexic pathology" (Chapter 2), although it seems clear that their patterns of control differ. It is suggested that while anorexics exhibit "too much" control, bulimics alternate between "too much" and "too little" control, patterns evident in their families.

While further research is necessary in order to validate these findings, a tentative suggestion is that these patterns be identified and dealt with in the treatment both of families and individuals. It may be that a change of focus will result in a better prognosis for bulimic individuals (whether "anorexic" or not), stemming from the recognition that their bulimic pattern is separate and different from the restricter anorexic pattern, and that the respective functioning of the families of those with bulimic symptoms and restricter anorexics although similar, is different.

It is hoped that this study will provide the basis for future research in the area of eating disorders, not only in terms of the results obtained but also in term of the instrument used. Despite its limitations, it is suggested that the McMaster Model of Family Functioning is a valuable clinical and psychometric tool which may be of use in providing both

quantitative and qualitative data on family functioning from a systems perspective, a necessity in a field which abounds with anecdotal, historical and descriptive data.

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APPENDICES

APPENDIX 1

MEDIA ARTICLE

RESEARCH ON WEIGHT CONTROL METHODS

We live in a society where keeping slim while eating 'all the right foods' and exercising is valued highly. Since many people struggle with food and weight problems, it is only natural that new methods of weight/body control will receive much attention. In the past, one such method has received considerable attention, from both the media and mental health professionals, namely Anorexia Nervosa. However, in recent years another method of weight control appears to be becoming more popular. This method involves binge-eating and purging and is known as Bulimia. Although there is a growing body of research on this topic, not much work has been done in South Africa, particularly with regard to the families of people who employ this method of weight control.

I am currently involved in research on families for the Department of Psychology at the University of Cape Town and urgently require people who employ this method of weight control to participate in such a study. Participation would entail brief interviews with the respondent, to be conducted in Cape Town, and the completion of questionnaires by all family members.
The identity of all participants will be kept strictly confidential but should you wish you are free to use a pseudonym. Interested people can contact LILIAN ING after 7 pm at (Telephone number).

All participants will receive written feedback on the findings once the research is completed.

APPENDIX 2

INTERVIEWS WITH BULIMICS

PHASE ONE

1) Height:
   Weight:
   Desired/ideal weight:

2) Any eating peculiarities as a child?
   Weight problems as child?
   Eating problems as child?
   Food fads?
   Family eating problems?

3) When did eating problem begin? Age? Weight? Height? What precipitated problem? What was happening in your life at the time? Dieting? Do you feel you have a realistic perception of your body? Too thin/fat/average? Give a chronological account of eating problem, from beginning to present. Include following info if relevant: An account of episodic binge-eating. When does it occur, how frequently, what precipitates, pattern. What is eaten? Does this vary? Has it varied over years ? What do you call "a binge"? Is it planned? Describe food eaten. Why do you choose this kind of food? Do you eat secretly? Is food eaten rapidly? Enjoyed? Once begun, do you seek additional food to continue? Do you feel eating pattern is abnormal and fear being unable to stop eating? Do you try to resist urge to eat? Do you feel down, guilty, self-disgust at any time? When? What do you think makes you do this? What stops the binge? Have you ever eaten to the point of stomach being distended? Have you ever induced vomiting? Use of laxatives - describe use. Has pattern varied? Kind? When are they taken? Ever used appetite supressants? Diuretics? Do you attempt between binges to control your weight? How? Do you ever fast? Does your weight fluctuate?

How many kg's? Do you feel your life is dominated by thought of food? Do you focus on how others see you and react to you? Do you have periods of normal eating?
Is there anybody else in your family who has a weight problem? Eating conflicts?

4) Have you ever suffered with depression? Physical complaints you believe may be due to Bulimia?
Give account of depressive symptoms (if relevant).
Give account of physical complaints (if relevant).
Age of first period? Have they been regular since then? Have you ever had absence of periods? How long? At present? Cycle? Contraception?

5) Brief account of events you feel made a lasting impression on you. Significant events in your life, your family's life.

6) Brief description of your personality characteristics:

7) Present relationships? Sexual? Or past relationship - when ended/why? Length of relationship? Brief description of kind of relationship. What does it do for you?

8) Do you live at home? Alone? How long have you been away from home?

9) Description of family e.g. their ages, personalities, occupations - and any characteristics you feel to be of importance. e.g. deaths, separations etc.

10) How and when did your parents discover you suffered with Bulimia?

11) <u>Family History of Illness</u>:
Medical illnesses in family/extended family
Psychiatric illnesses in family

12) Any other issues you feel are relevant:

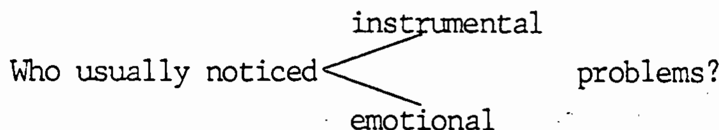
3/...

PHASE THREE

Rate how your family functioned prior to the onset of your problem - (mention significant event)

Problem Solving

1) When there have been problems in your family, who usually first noticed the problem?*
   Did the whole family see the problems in the same way?



2) When you as a family had instrumental problems who did you tell?
   When you as a family had emotional problems who did you tell?
   Is that who you would usually tell?
   When did you tell them?
   Do you think others noticed the problem, but did not tell anybody?
   What stopped you/others?

3) Did you as a family handle problems by thinking of alternatives?
   Did you discuss these with a/several family members?
   Who? Did others/a specific person help you to resolve problems?

4) How did you as a family decide what to do?
   Who decided?
   How did you decide on that alternative?

5) Did you do what you decided as a family?
   After deciding, did someone check to see that things (instrumental and emotional) were done? Who usually?

6) Did your family ever discuss how they think they did in handling problems? Did they ever go over the problems and what happened?

7) Give a general picture of the way your family solved instrumental/

emotional problems?
Which problems caused difficulty?
Mention any other areas you feel were problematic?

*These and following questions represent the guidelines used by the researcher in the semi-structured interview and are not intended to reflect actual words used.

Communication

1) Did people in family talk much with each other?
Who did most talking together? How frequently, regularly?
Did you feel people could tell things freely or were they guarded and had to qualify what they said?

2) Issues
Instrumental / Emotional

Mother - Father
Mother - Sibling 1
- Sibling 2
- Sibling 3
Father - Sibling 1
- Sibling 2
- Sibling 3 etc.
Siblings - Siblings

How did the above people communicate? Specify:
Clearly/straight and directly to the person concerned or
Clearly/straight but indirectly i.e. via someone else or
Masked and directly (masked = hinting at things) or
Masked and indirectly.

Did you let each other know you understood what the other was saying? Did you feel you could get your ideas across to others? Who? Did you feel others understood you? Instrumentally? Emotionally? What happened when they didn't? What was the problem when you tried to tell others about instrumental/emotional issues?

5/...

Roles

1) Who was breadwinner? Were there separate bank accounts? Joint cheque account? Credit? Who bought groceries and made meals? Was it always that way? If not, specify. Who bought clothes for family members? Who paid? How many cars? How did the family used to get around? Did you ever go places together?

2) Who did you/other members go to when you needed someone to talk to? When you were upset? Was it helpful? Which parent was the comforter? How did they handle it when a child was upset? Did each parent do similar/different things? Did parents divide availability to children?

3) Have you ever been aware of parental conflict? When? Give broad outline.

4) Who supervised education? Who helped with homework? Who dealt with school? How were various stages of growing up handled by parent? Who got involved with growing up issues? Always? Who was responsible for teaching manners? Sex education? Social skills? With whom were vocational choice, change of jobs discussed? How did you help each other develop and do your own thing?

5) Who was included in major discussions? Who had the final say? Whose opinion was taken if no accord reached? Who kept track of health of members? Who decided when you see the doctor? Who decided if professional help needed? Who handled the money? Accounts? Who got involved in large purchases? Who did housework? Who had activities outside house? Who took care of repairs? How were decisions to renovate/redecorate house taken? Efficiently? Who saw to car repairs? Who handled discipline? How?

6) How did family decide who did specific chores? Was it talked about? Is that just the way it developed? Did you

think decisions needed to be handled differently? Did you feel some people had too many chores? Overburdened? Were some people often asked to do unreasonable jobs or were requests reasonable?

7) Who checked whether chores done? How? What happened if these weren't done?

Affective Responsiveness

1) Do you think your family experienced feelings more/less intensely than is reasonable in situations? Did you all respond in this way? Which feelings were ignored or not expressed? Did your family under-respond in terms of emotions? Which ones?

2) How was love, kindness, affection, tenderness expressed/responded to in family?
How was anger, rage, hate expressed/responded to?
How was fear expressed/responded to?
How was sadness, depression, hurt expressed/responded to?
How was tension expressed/responded to?

Affective Involvement

1) Who in your family cared about what is important to you? Why did you think they cared? Was there anything that bothered you about the way they showed interest? How did they let you know they were concerned for you? Did they ever show too much interest? Were family members interested in each other's interests? What were your interests? How did rest of family feel about these? Were they not/too interested? For your sake or theirs? Did you feel that other members went their own way and did not care what happened to you? Did you feel you related like strangers?

2) Who irritated you most in family? Did you feel people in family were over-protective or over-involved in your life? How did they do that? How did you handle it? How did you get them to stop it?

7/...

Were you satisfied with your relationship with your parents - your Mother; Father; close enough? Difficult?

Behaviour Control

All families have rules for behaviour in various situations. In which areas were the rules most important in your family? - *Physically dangerous situations; situations involving meeting/ expressing psychobiological needs; situations involving inter- personal socialising behaviour? Were rules clear? Were they the same for everyone, or did it vary? If so, how?

Was everyone expected to eat together? Were there table rules for table manners; for bed; dressing; bathing? What were they? Were they consistent or did they vary? Were allowances made for special situations? Were the rules the same for everyone?

Were the rules clear about how to relate to each other e.g. was shouting, hitting allowed? Were there different rules for different people? How much freedom were you allowed? Were you able to negotiate these? Were there rules you felt were unfair? Did parents agree in all matters? Where did they differ? Did kids know parents agreed/disagreed? How were rules enforced? Who did enforcing? Did you know what to expect if rules were broken? Was it consistent or could you get away with it sometimes? Who was toughest in terms of punishment and consequences? Always, or did they give in later? Did each parent back the other up?

*Physically dangerous situations e.g. talking to strangers, going out alone, crossing road etc.
Situations involving meeting/expressing psychobiological needs e.g. rules about sex, table manners, eating, hygiene etc.
Situations involving interpersonal socialising behaviour e.g. rules about social contact, expressing anger/love, having friends, boyfriends etc.

APPENDIX 3

LETTER TO PARENTS

Researcher's Address

As you have been informed by your daughter, I am currently involved in research on eating problems for the Department of Psychology at the University of Cape Town and am writing to you because your daughter has agreed to participate in such a study.

In order to gain more understanding about these problems we are asking you as a family to participate in this project. An important aim of this project is to learn more about the ideas and opinions of different members of the same family. In order to do this, I need to have every family member over the age of twelve complete the attached questionnaires. It is important that each questionnaire be completed by each individual, without the content being discussed by the family. I shall also be meeting with your daughter briefly and she will be completing such a questionnaire. In order to obtain a true picture of the many different points of view in different families it is important to the success of the study that each selected family participates in the study. The identity of all participants will be kept strictly confidential and as is the case with all scientific studies, the findings will be put into a statistical report so that no individual's views can be identified. All participants will receive written feedback on the findings once the research is completed.

If you have any questions about the study, feel free to contact me. I think you will find that participating will be an interesting experience and will also be a useful contribution to the understanding of families.

I would appreciate it if the questionnaires could be returned to me before _________________ or as soon as possible thereafter.

Sincerely

LILIAN ING

APPENDIX 4

FAMILY ASSESSMENT DEVICE

UNIVERSITY OF CAPE TOWN

DEPT OF PSYCHOLOGY

You are being asked to help us check out an assessment questionnaire that we want to use in our study on eating problems. The questionnaire is made up of sentences that might apply to a family. You, and the other members of your family who are over twelve, will be asked to rate these sentences as they apply to your family. This is an exploratory study, so we have no clearcut ideas or expectations concerning your own unique and individual experience. The information we gain will make a useful contribution to our understanding of families. If you have questions about the study, you can contact the researcher about them. You are free not to fill out this questionnaire if you do not wish to.

All information you provide is confidential. Any published reports that include information you provide will in no way identify you or your family.

I have read the above statement which describes the study and confirm that I consent to the terms. I have discussed it with ______________________/ the researcher who has answered my questions. I agree to participate in the above study.

______________________________ ______________________________

(Name/Pseudonym) BLOCK CAPITALS (Signature)

______________________________ ______________________________

date researcher or clinician

FAMILY ASSESSMENT DEVICE QUESTIONNAIRE

INSTRUCTIONS:

This booklet contains a number of statements about families. Please read each statement carefully, and decide how well it describes your own family. You should answer according to how you see your family.

For each each statement there are four (4) possible responses:

Strongly Agree (SA)	Check SA if you feel that the statement describes your family very accurately.
Agree (A)	Check A if you feel that the statement describes your family for the most part.
Disagree (D)	Check D if you feel that the statement does not describe your family for the most part.
Strongly Disagree (SD)	Check SD if you feel that the statement does not describe your family at all.

These four responses will appear below each statement like this:

41. We are not satisfied with anything short of perfection.

_____ SA _____ A _____ D_____ SD _____

The answer spaces for statement 41 would look like this. For each statement in the booklet, there is an answer space below. Do not pay any attention to the blanks at the far right hand side of each answer space. They are for office use only.

Try not to spend too much time thinking about each statement, but respond as quickly and as honestly as you can. If you have trouble with one, answer with your first reaction. Please be sure to answer every statement and mark all your answers in the space provided below each statement.

If you feel you have additional information which will elaborate on your answers, please feel free to add your comments to this questionnaire.

page 1 ID ____ ____ ____

1. Planning family activities is difficult because we misunderstand each other.

____ SA ____ A ____ D ____ SD ________

2. We resolve most everyday problems around the house.

____ SA ____ A ____ D ____ SD ________

3. When someone is upset the others know why.

____ SA ____ A ____ D ____ SD ________

4. When you ask someone to do something, you have to check that they did it.

____ SA ____ A ____ D ____ SD ________

5. If someone is in trouble, the others become too involved.

____ SA ____ A ____ D ____ SD ________

6. In times of crisis we can turn to each other for support.

____ SA ____ A ____ D ____ SD ________

7. We don't know what to do when an emergency comes up.

____ SA ____ A ____ D ____ SD ________

8. We sometimes run out of things that we need.

____ SA ____ A ____ D ____ SD ________

9. We are reluctant to show our affection for each other.

____ SA ____ A ____ D ____ SD ________

10. We make sure members meet their family responsibilities.

____ SA ____ A ____ D ____ SD ________

11. We cannot talk to each other about the sadness we feel.

____ SA ____ A ____ D ____ SD ________

12. We usually act on our decisions regarding problems.

____ SA ____ A ____ D ____ SD ________

13. You only get the interest of others when something is important to them.

    ______ SA ______ A ______ D ______ SD ________

14. You can't tell how a person is feeling from what they are saying.

    ______ SA ______ A ______ D ______ SD ________

15. Family tasks don't get spread around enough.

    ______ SA ______ A ______ D ______ SD ________

16. Individuals are accepted for what they are.

    ______ SA ______ A ______ D ______ SD ________

17. You can easily get away with breaking the rules.

    ______ SA ______ A ______ D ______ SD ________

18. People come right out and say things instead of hinting at them.

    ______ SA ______ A ______ D ______ SD ________

19. Some of us just don't respond emotionally.

    ______ SA ______ A ______ D ______ SD ________

20. We know what to do in an emergency.

    ______ SA ______ A ______ D ______ SD ________

21. We avoid discussing our fears and concerns.

    ______ SA ______ A ______ D ______ SD ________

22. It is difficult to talk to each other about tender feelings.

    ______ SA ______ A ______ D ______ SD ________

23. We have trouble meeting our bills.

    ______ SA ______ A ______ D ______ SD ________

24. After our family tries to solve a problem, we usually discuss whether it worked or not.

    ______ SA ______ A ______ D ______ SD ________

25. We are too self-centered.

_____ SA _____ A _____ D _____ SD _______

26. We can express feelings to each other.

_____ SA _____ A _____ D _____ SD _______

27. We have no clear expectations about toilet habits.

_____ SA _____ A _____ D _____ SD _______

28. We do not show our love for each other.

_____ SA _____ A _____ D _____ SD _______

29. We talk to people directly rather than through go-betweens.

_____ SA _____ A _____ D _____ SD _______

30. Each of us has particular duties and responsibilities.

_____ SA _____ A _____ D _____ SD _______

31. There are lots of bad feelings in the family.

_____ SA _____ A _____ D _____ SD _______

32. We have rules about hitting people.

_____ SA _____ A _____ D _____ SD _______

33. We get involved with each other only when something interests us.

_____ SA _____ A _____ D _____ SD _______

34. There's little time to explore personal interests.

_____ SA _____ A _____ D _____ SD _______

35. We often don't say what we mean.

_____ SA _____ A _____ D _____ SD _______

36. We feel accepted for what we are.

_____ SA _____ A _____ D _____ SD _______

37. We show interest in each other when we can get something out of it personally.

    ______ SA ______ A ______ D ______ SD ________

38. We resolve most emotional upsets that come up.

    ______ SA ______ A ______ D ______ SD ________

39. Tenderness takes second place to other things in our family.

    ______ SA ______ A ______ D ______ SD ________

40. We discuss who is to do household jobs.

    ______ SA ______ A ______ D ______ SD ________

41. Making decisions is a problem for our family.

    ______ SA ______ A ______ D ______ SD ________

42. Our family shows interest in each other only when they can get something out of it.

    ______ SA ______ A ______ D ______ SD ________

43. We are frank with each other.

    ______ SA ______ A ______ D ______ SD ________

44. We don't hold to any rules or standards.

    ______ SA ______ A ______ D ______ SD ________

45. If people are asked to do something, they need reminding.

    ______ SA ______ A ______ D ______ SD ________

46. We are able to make decisions about how to solve problems.

    ______ SA ______ A ______ D ______ SD ________

47. If the rules are broken, we don't know what to expect.

    ______ SA ______ A ______ D ______ SD ________

48. Anything goes in our family.

    ______ SA ______ A ______ D ______ SD ________

page 5 ID ____ ____ ____

49. We express tenderness.

_____ SA _____ A _____ D _____ SD _______

50. We confront problems involving feelings.

_____ SA _____ A _____ D _____ SD _______

51. We don't get along well together.

_____ SA _____ A _____ D _____ SD _______

52. We don't talk to each other when we are angry.

_____ SA _____ A _____ D _____ SD _______

53. We are generally dissatisfied with the family duties assigned to us.

_____ SA _____ A _____ D _____ SD _______

54. Even though we mean well, we intrude too much into each others lives.

_____ SA _____ A _____ D _____ SD _______

55. There are rules about dangerous situations.

_____ SA _____ A _____ D _____ SD _______

56. We confide in each other.

_____ SA _____ A _____ D _____ SD _______

57. We cry openly.

_____ SA _____ A _____ D _____ SD _______

58. We don't have reasonable transport.

_____ SA _____ A _____ D _____ SD _______

59. When we don't like what someone has done, we tell them.

_____ SA _____ A _____ D _____ SD _______

60. We try to think of different ways to solve problems.

_____ SA _____ A _____ D _____ SD _______

16 MAR 1988