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A Family Systems Perspective on Recovery from an Eating Disorder

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> And out of the blue I understood that the family photograph held the answer. That it was really a portrait of a kind of reckless courage, a testament to the great loving carelessness of the heart of every family's life, even ours. That each child represented such risk, such blind daring on its parents' parts–such possibility for anguish and pain–that each one's existence was a kind of miracle.
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> —*Family Pictures*, Sue Miller

Mary Brown, fourteen years old, 5 feet, 6 inches tall, and weighing 95 pounds, was brought to the Wilkins Center by her mother, Jean. Jean could not understand what had caused Mary's recent refusal to eat and her irritable behavior. According to Jean, Mary had always been an "easy" child, had excelled at school, and had been cooperative at home. Now she was not eating and was having mood swings that upset everyone in the family.

Family therapists think about the development of an eating disorder as a signal that the family is under stress. By stress we mean the

emotional and physical reactions we experience as a result of some hurt, loss, pain, anxiety, depression, or sadness that underlie the development of a symptom like an eating disorder. The focus of recovery is the process of understanding the sources of the stress in the family and finding healthy ways to deal with it.

Family therapists focus on stress in the family instead of stress in the individual with the eating problem because they base their interventions on systems theory. Systems theory tells us that all parts of a system are interrelated, that one part of a system cannot be understood without knowing the other parts, and that the whole is greater than the sum of the parts.

A way of conceptualizing the tenets of systems theory is to envision a mobile hanging from the ceiling, all of its pieces interconnected and moving in relation to one another. If we change one piece of the mobile, the whole structure will be thrown out of kilter. To get the mobile back into equilibrium, we would have to remove or add another part or adjust the position of the parts (Richardson 1984). The point is that we cannot know the effect of changing one piece without viewing it as a part of the whole.

A family is another example of a system. In our society we define a family as a system of individuals who have come together through birth and marriage and whose interrelatedness extends backward encompassing all past generations. The behavior, movement, growth, or change in each member affects the behavior of all other members of the family, directly or indirectly. A family is like a mobile, a system of interrelated individuals, each in delicate balance with the others to form a balanced movement of the whole. Feelings or emotions experienced by one family member will affect the feelings and emotions of other family members. Stress experienced by one family member will affect other family members, no matter how carefully we try to keep it to ourselves! Families are emotionally connected.

Focus on the family during the recovery process is not meant to imply that the family is to be blamed for the eating disorder. Blame is not useful or valid in family therapy. Development of an eating disorder is much too complicated a process to blame on any particular factors or people. The factors involved are infinite. What we do know is that if we can change a few of these factors, we can relieve

the symptom. This is the piece of reality that is relevant. When a family therapist asks a family member to change a way of behaving or asks a family member to realign a relationship, the request in no way implies blame for the problem. To the contrary, it implies confidence in the ability of that family member to be an agent of change in the family.

To understand and treat an eating disorder, three levels of systems need to be addressed. These are the systems that play a part in symptom development, symptom maintenance, and in recovery:

1. The larger sociocultural system;
2. The family system; and
3. The physiological and emotional systems of the person with the symptom.

Because the sociocultural system and the physiological and emotional systems of the symptomatic family member are addressed elsewhere in this book, I will just briefly define them in the system's context and then return to the subject of this paper, the family.

THE SOCIOCULTURAL SYSTEM

Societies have historically reinforced women's sacrifice of their health in the pursuit of the current ideal of feminine beauty. Examples are the rib-breaking corsets of several generations ago to promote the wasp waist and the practice of binding feet in China (Root, Fallon, and Friedrich 1986). In our present-day society, the current ideal of feminine beauty is to be thin. As a culture we have become obsessed with thinness and issues concerning food, appearance, and body fat, especially for girls and women. Miss America contestants and Playboy Bunnies have gotten progressively thinner in our generation (Garner et al. 1980). Orbach (1982) points out that girls and women receive many conflicting messages about how to get approval, acceptance, and a sense of well-being. But one message is crystal clear–everything will fall into place if a woman is thin. The media gives the message that being thin is not only beautiful but powerful. People flock around thin girls and women. They look self-

confident and assured. Thus being thin is equated with power. No wonder studies show that 60 percent of girls have dieted by the age of eighteen (Root, Fallon, and Friedrich 1986). Societal systems are a major influence in the development and maintenance of eating disorders.

THE PHYSIOLOGICAL SYSTEM

For genetic or biochemical reasons, some bodies seem to gravitate toward a higher fat content than others. When people try to diet to a weight below their biologically determined weight in order to conform to the cultural ideal, the physiological response is starvation. The anorexic is in a constant state of starvation. In bulimia, periods of starvation alternate with periods of bingeing and purging. The following gives us an understanding of what happens when people do not eat.

A famous study by Keys, Taylor, and Grande (1950) at the University of Minnesota indicated that when young, healthy, psychologically normal men cut their caloric intake by half for six months and lost 25 percent of their body weight (similar to what takes place in anorexia nervosa), they developed a range of bizarre symptoms: a constant preoccupation with food and difficulty concentrating on anything else; tendencies to hoard food and to spend hours bingeing; problems with depression, irritability, outbursts of anger, anxiety, nervousness, apathy, and low sexual desire; and trouble with alertness, comprehension, and judgment. Physical symptoms included sleeplessness, dizziness, headaches, hypersensitivity to noise and light, reduced strength, poor motor control, edema, and visual disturbances. These symptoms are the same as those seen in clients with eating disorders. Thus this study tells us that many of the symptoms we observe in persons with eating disorders are directly related to the starvation process itself. (For more details of physiological aspects, see the first paper in this book.)

A person develops an eating disorder only when she is experiencing emotional stress or is a conduit for family emotional stress, but once the eating disorder has developed, many of the symptoms are physiologically based in the starvation response. Clearly the physio-

logical and emotional systems of the person with an eating disorder are intertwined. Efforts toward emotional recovery must be preceded or accompanied by recovery of the physiological system.

A further complication is that eating disorders become addictions, psychologically and physiologically. However, unlike addiction to alcohol or other drugs, one cannot stop using the substance. One has to eat. This is one of the reasons that eating disorders are difficult to treat.

THE FAMILY SYSTEM

It is believed that individuals organize into family units to carry out certain necessary tasks, like raising children, nurturing and supporting one another, sharing in household duties, and providing security for one another. To carry out these tasks, a family and its members need order (or predictability) and balance. As with any other system, a family will resist change and in the face of change will gravitate toward reestablishing order and balance. "Order" refers to the family's predictable patterns of behaving and reacting, as well as the traditional roles played by members of that particular family.

This all-important order in the family is achieved by "family rules." Family rules are of two kinds, spoken and covert. Spoken rules might include those concerning interrupting one another when talking, and those concerning bedtime, homework, when to watch television, or whose job it is to take out the garbage. Because these rules are spoken, they can be discussed, even questioned, in some families. The covert rules are understood and agreed on by everyone, but they are not openly acknowledged or discussed and may even be denied. For instance, in some families it is not okay to be angry but it is all right to be depressed. In other families men are not supposed to be afraid, but acting angry is acceptable. In some families arguing is not allowed. In other families arguing is the way family members connect with one another (Richardson 1984). Spoken and unspoken rules tend to be passed down from generation to generation (Kerr and Bowen 1988).

The purpose of rules, spoken or covert, is to control the way people relate to one another and to outsiders. The rules keep order, give

a family predictability, and keep everything in balance as long as everyone plays by the same ones (Richardson 1984). In most families the spoken rules are adjusted and changed as the needs of the family and family members evolve during the normal course of the life cycle. The unspoken rules also change, but with more difficulty, since the family is often not consciously aware that they are operating under these particular rules.

All families operate with both kinds of rules. A rule only becomes a problem when it inhibits family members from dealing directly with stress or anxiety. When such a prohibition has been in effect for a number of generations, stress builds up and becomes part of the family heritage, which is passed down from generation to generation much like family heirlooms. Stress buildup is not a direct result of the pain and losses the family encounters over the generations. Rather, it results from the effect of the stressful events on the relationships within the family. And this effect is dependent on the family rules for handling stressful events.

Sources of Stress in the Family

Family therapists work with the family to understand what is stressful and how the family deals with it. I ask families to imagine a stress bucket that sits in the middle of the living room floor. All the stress experienced or inherited by each family member is poured into the bucket. A symptom in the family, such as an eating disorder, is an indication that the bucket has overflowed. The family has developed stress buildup. For the purpose of organizing our thinking we can look at stress as coming from three main sources.

Predictable family life-cycle stress. The first source results from predictable family life-cycle stages (Carter and McGoldrick 1989). These stressors are normal and expected, and result from the family's evolution over time. Therapy with families has shown that certain stages of the family life cycle are particularly stressful: birth of the first child, children in adolescence, and children maturing and going off on their own. This is true partially because of the tremendous changes involved in the ways family members relate to one another as a result of these transitions.

For example, a couple with a new baby may be joyous about the new addition. However, they must also adjust their marital relationship to include a relationship as coparents. In addition, as husband and wife take on parental roles, they find that the relationship with their own parents is changing to include their own roles as parents and their parents' new roles as grandparents. All this change is normal, but it is stressful. There will be a period during which the family mobile is out of kilter as a result of the birth. In time, as new ways of relating to one another are developed, the family mobile will find balance in its altered state and the family can again go about its business.

Unpredictable stress. The second category of stress results from unpredictable events that take place in the family's environment, such as illness, war, or financial setbacks like the loss of a job. This category includes daily tensions like someone being mean to a family member or having a bad day at the office or at school. All these concerns, major and minor, land in the family stress bucket. However, each time a family member copes with stress in a healthy way by changing the situation that caused the stress or by negotiating a settlement with someone who made him or her angry or even by just having a good cry and letting the hurt go, stress is ladled out of the bucket.

Inherited stress. The third source of stress results from painful situations that were not laid to rest in previous generations and are passed down to the next generation. This stress is made up of all the hurts, losses, and angers that have been experienced by previous generations but have not been worked through to an understanding or peaceful resolution.

An extreme example is a family with a history of loss in the Holocaust. I have encountered five anorexic girls during the last several years who have a history of loss through the Holocaust in their grandparents' generation. The grandparents of the eating disordered child suffered the overwhelming pain of losing much of their family of origin to the Holocaust in Europe. They escaped, married, and had children, whom they tried to protect from their overwhelming feelings of loss by not talking about their pain. It is the

grandchild who developed anorexia nervosa. It is unlikely that these grandparents would have been able to fully process their grief. Their loss was too overwhelming. Their child, the mother or father of the anorexic patient, who is one generation removed, is better able to work with the grandchild to process the pain, helplessness, anger, and often guilt that has been passed down through the generations. The same need to process hurt or loss exists in families that have a history of abuse, incest, alcoholism, depression, untimely death, or other painful event that has not been fully processed. Although it is not uncommon to encounter a history of extreme tragedy in families of persons with eating disorders, a simple cause-and-effect relationship should not be assumed. Development of an eating disorder is far more complex than that would imply.

As unprocessed emotional issues in one generation are passed to the next, stress builds up. Further, the more anxiety and stress that is passed down in a family, the more vulnerable that family is to added stress from the family life cycle or unexpected events and the more likely that someone in the family will develop a symptom. (Sometimes one can only guess why one family member develops the symptom rather than another. Why the symptom that develops is an eating disorder is often a mystery, although it can be related to the importance the family places on food or appearance.)

Family therapists assume that stress buildup is related to faulty interactions between people. The closer people are to one another emotionally, the greater the possibility of stress buildup in the presence of rigid family rules. Sometimes individuals are unable to deal directly with hurt or anger because of circumstances beyond their control or because family rules prohibit them from working through issues. When the persons directly involved do not deal directly with their hurt or anger, for example, on a one-to-one basis, the pain can be relieved by *triangulating*, that is, bringing in another person or persons. This unconscious and natural process relieves the stress in the original parties but often results in transferring stress onto the third party. This process of triangulating is the way stress is passed down through generations or among family members.

The following is a common example of triangulating: Marge finds herself getting angry at her husband, Fred, who arrives home for dinner later and later. She has difficulty confronting him directly, so

she calls her mother and tells her in great detail about what a louse Fred has become. The effect of this call to Mom is to lessen Marge's anger and frustration because she has let off steam. But there are other effects: The issue between Marge and Fred is not dealt with, and Mom finds herself worrying about her daughter's marriage and what, if anything, she should do to help. Thus stress has been transferred from the original twosome to a triangulated party, Marge's mother.

Triangulating is normal. We do it all the time. If we confronted every person who slighted us, we would be exhausted. If the clerk in the market is rude, we might grouse to our best friend and just let it go. It is of concern, however, when we habitually involve a third person to lower tension in a close relationship instead of dealing directly with the issues in the relationship itself.

The example of Marge and Fred is an example of triangulating up the generations. Far more common is the tendency to triangulate down the generations. What follows is an example of how stress was passed down in a family, how it built up, and how it then resulted in the development of a symptom, in this case, an eating disorder. The following case is not meant to explain the cause of eating disorders, as no one really fully knows their cause.

Case Study

John had gotten more and more involved in his work so that he seldom returned home until the kids were ready for bed. Ann, his wife, became increasingly angry and resentful that she was left with the lion's share of the parenting responsibility. She was also hurt by the loss of his companionship. In her family of origin she learned that not only was it not nice to get angry, it wasn't even nice to feel angry. She also learned to "make the best of things," "keep a stiff upper lip," and "don't make waves." (These are examples of covert family rules.) She learned these rules by observing that her parents never dealt directly with each other about dissatisfactions. Ann couldn't even allow herself to have angry feelings, much less express them. Instead of confronting John directly, she became depressed and irritable. John sensed that all was not well with Ann, but he, too, had learned not to ask or "rock the boat" (his family's rule). His solu-

tion was to stay at the office even later to avoid the possibility of conflict. The tension continued to build.

One way tension can be resolved without having to confront the scary, painful issues between this couple and thus break the family rules is to focus on something else. If John and Ann can get interested in a third person or object or issue, then tension between them will lessen or at least be put on hold.

Children unconsciously cooperate in this unspoken need because little else is more frightening to them than tension between their parents. Children can distract their parents from the tension in lots of ways: by fighting, getting bad grades, keeping messy rooms, taking drugs or alcohol, and of course by developing an eating disorder.

At the same time that the tension was building between John and Ann, fourteen-year-old Suzy, who was feeling tense and out of control herself, decided to go on a diet. Was she feeling tense because her parents were tense? That may have been part of it. She may also have been feeling tense because she had just moved from junior high school to senior high. She may have been feeling anxious about all the physical changes of puberty, as well as the new social pressures. A host of issues were involved. This was a family that had not learned to deal with stress or anxiety directly, so wherever the stress was coming from it was probable that Suzy would deal with it in an indirect manner.

Eating disorders, as well as other symptoms, are indirect ways of dealing with stress resulting from a difficult or painful experience or unacceptable feelings. Whatever form the diet takes that develops into an eating disorder, it involves an obsession with what to eat and what not to eat. This obsession with food acts like a mask or a smoke screen. It gets Suzy off the track of what is really bothering her. So in one sense it is an effective response to stress and anxiety. It is like "changing the subject."

Not only does it distract Suzy from her own tensions, but the "diet" changes the subject in the family as well. When Suzy stopped eating, Ann and John began to focus on Suzy. They worried, cajoled, got angry, and had long talks about what to do. In the process of concentrating on Suzy the subject was changed, and the tension between the two of them went underground.

In time, however, as Ann and John became more and more focused on Suzy's eating problem, the power struggle between Suzy and her parents became more intense and the three of them became trapped in a circular pattern of reaction to one another from which it became increasingly difficult to escape. Over time, the eating disorder took on the properties of an addiction, so that Suzy became unable to stop. Thus the initial attempt to establish control over her life, as noted earlier, backfired, and she and the whole family were trapped.

TREATMENT

Treating an eating disorder such as Suzy's requires that it be approached from at least two perspectives. One is designed to deal with the symptom itself, the other to deal with the underlying stresses that contribute to the development of the eating disorder in the first place.

TREATING THE SYMPTOM

I often suggest dealing with the symptom by putting the person with the eating disorder in charge of her eating. This does not mean abandoning her to her own devices. It requires that a contract be developed with her and her family outlining what is expected of them, how the contract will be monitored, and what the consequences will be for not living up to the contract. For example, she can resume field hockey once her weight reaches a particular level, or she may go on a trip if she reaches a certain weight by summer. Contracts should also spell out clearly the criteria for hospitalization and how that will be implemented, if necessary. To help the individual take charge, she is given a support network. Key figures are the medical internist, who can provide regular feedback on her progress and state of physical health, and the nutritionist, who can work closely with her on meal plans and, most important, provide her with information and understanding regarding the physiology of starvation and recovery. (The physical process of beginning to eat

normally again is difficult because the digestive system and metabolism have gone into slow gear. Papers 1 and 2 of this book deal with these aspects of recovery in greater depth.

When families initially come for treatment, the parents are primarily concerned with managing the day-to-day family life of a child with an eating disorder, that is, managing the symptom. It is frightening to observe a child starving. Parents find themselves going to extraordinary lengths to encourage or force their child to eat.

Tara Smith, for instance, was fifteen when she became anorexic. Mrs. Smith spent hours wracking her brain for foods to buy or cook that would entice Tara to eat. Mr. Smith would bring home the special treats that Tara had always loved, only to have them rejected. In the evening he would drop everything and go to the store because Tara mentioned that some strawberry ice cream might taste good. On his return she had changed her mind. He became furious and berated Tara for being so self-centered. Mrs. Smith had fallen into the habit of cutting Tara's food into tiny bites so it would be easier for her to swallow. She asked the family's cooperation in adjusting their dinner time and menus to suit Tara's schedule. Tara's brother, John, had been told: "Don't argue with Tara. We don't want to upset her. Don't make Tara angry; maybe she won't eat. Don't say or do anything to cause stress to Tara." On the other hand, Mrs. Smith found herself constantly nagging Tara: "Won't you just eat one cracker? What did you have for lunch? Have you eaten breakfast?"

The family's emotional life had become hostage to the eating disorder. Tara's parents were physically and emotionally drained in their efforts to coax Tara to eat. John was angry and felt that the family's attention was revolving around Tara.

Because families often come into therapy describing a situation similar to the Smiths', the family therapist, as the first order of business, will commonly try to help the family step back from issues around eating and let the adolescent take charge. The idea is that once food is no longer the arena of a power struggle in the family, the adolescent will begin to develop her own judgment and make more responsible decisions about food (with the support of her nutritionist and therapist). This, of course, is one goal of therapy—that the adolescent becomes responsible for maintaining the health of her own body, a metaphor, if you will, for developing autonomy.

This process is far more complex than it sounds, but the simplest way to envision it is to imagine the family treating the adolescent as though she were eating normally. Only occasionally buy special foods. Expect her to adjust to the family's meal schedule. Avoid overprotecting her from the emotional life of the family. Perhaps most important, the parents need to reach agreement with each other as to the best ways to approach these changes so that they can present a united front and thus not sabotage each others' efforts (Siegel, Brisman, and Weinshel 1988). The process of family members stepping back from managing the adolescent's eating is a long and difficult one. Each step must be fully explored, planned, and reported in the next session. Did the adolescent eat less or more when Mom stopped cutting her food? How did she feel? How did everyone else respond and feel? If Mom was not able to make the change, what interfered?

The family's retreat from its overinvolvement in the eating disorder symptom must be undertaken with great care. The therapist needs to assist families in developing as complete an understanding as possible as to the effect of change on each family member and the family system. If Mom or Dad stops worrying about what Sue is eating, will Sue feel unloved and abandoned and become more depressed? Will Mom and Dad turn to worries concerning another child? No longer distracted by the eating disorder, will they become aware of strains in their own relationship? Will they come face to face with the often painful tasks demanded by their own life-cycle stage, such as coping with middle age, the death of their own parents, and the realization of their own mortality, retirement, and empty-nest concerns? Focusing on the daily behavior of a sick child can distract family members from a variety of concerns. Before deciding how families should change the way they respond to food issues, I ask the family to explore as fully as possible what might confront them were the focus of concern to change.

TREATING THE UNDERLYING STRESSES

In looking for underlying stresses that contributed to the development of the eating disorder, keep in mind the idea of multicausality.

Let us return to our example of Suzy and her family. The tension between her parents did not cause Suzy's eating disorder. Going to high school did not cause it nor did the fact that Grandmother and Grandfather passed down the family rule: "Don't talk about dissatisfactions—it might cause conflict." Nor was it caused by the societal preoccupation with thinness. However, even though none of these caused the eating disorder, they can all be seen as possible contributing factors.

Having so many factors operating is helpful in treating the eating disorder. We know from systems theory that if one part of a system is changed, the whole system is affected. Thus a change in any one of the factors may have an impact on Suzy's eating disorder.

Parents are one of the most important influences in a child's life, and therefore they often wield the most power to effect change in the family and in the child. This is why parents are asked to take an active role in the treatment and recovery process.

The following is an example of how a family might experience significant change during the course of therapy:

I first saw Mary Brown when she was brought to the Wilkins Center weighing 95 pounds, as described at the beginning of this paper. It was the winter of her first year in high school. Susan, her sister, was a senior and was planning to leave for college the following September. From family life-cycle theory I knew that, consciously or unconsciously, the parents would perceive this event as the first step toward the day when their role as parents would diminish dramatically. Moreover, Mary's maternal grandfather had recently been critically ill. So in addition to facing her diminishing role as a parent, Mary's mother, Jean, was also confronting the inevitability of losing her own parent and was thus being reminded of her own mortality, another normal but stressful life-cycle event. Jean was not currently working outside the home, since she felt she should be home for her children during their teenage years. She had a clear sense of what Mary's behavior should be in areas such as eating, the clothes she wore, friends, and so forth, and devoted considerable energy to seeing that Mary, as well as Susan, followed her rules. In the past she had worked as an interior designer, and she missed that aspect of her

life. Mary's father, George, had a demanding job that kept him away from home many evenings.

So far I had not heard anything particularly out of the ordinary about this family. Yes, the family was experiencing a number of life-cycle changes, but so do all families. Talking further, I found that Jean's father was alcoholic. Her mother, though severely obese, managed to be the main support of the family. Jean spent her childhood worried about her mother's obesity, helping her mother with her younger siblings, and being very careful not to rock the boat by expressing any of her own wants or needs or negative feelings. Mary's father, George, came from a family in which the father had died young of lung cancer attributed to heavy smoking. His mother had been overweight, and this had been a subject of his father's scorn. George worked hard after school and weekends to help support the family. As in Jean's family, he grew up walking on eggshells, careful not to upset the family's tenuous balance.

Susan and Mary had participated in triangles for years, which had kept the lid on the level of stress experienced by the parents. A particularly significant triangle in this family worked in the following way.

Mary's father was distressed that his wife smoked a pack of cigarettes a day. Jean wanted to stop but was afraid that if she did she would become obese like her mother. Because smoking had been an important issue in George's family of origin, Jean's habit caused him a lot of anxiety. He could not bring himself to talk to his wife directly about his disapproval, but he and Mary talked about this together. On the one hand, Mary liked these conversations. She did not see her father often and this gave them a connection and a feeling of closeness. On the other hand, she felt uncomfortably disloyal to her mother. As long as George talked to Mary, his anxiety about Jean's smoking was tolerable and the level of tension between the parents was manageable. However, Mary found herself worrying more and more about her mother's smoking. The more Mary pleaded with her mother to stop smoking, the more adamantly Jean expressed her fear of gaining weight.

During the fall of her ninth-grade year, Mary began to diet. Initially this gave Mary a jolt of power. Her parents, especially her

father, complimented her on her control. In addition, she was pleasantly surprised to find that her friends at school were impressed with her bone thinness.

As she got thinner and thinner, she lost the ability to concentrate. She fell behind in school, withdrew from friends, was anxious, depressed, irritable, and was even angry and snappy at home, all symptoms of starvation.

These symptoms had a marked effect on the family. Mary's parents became increasingly anxious and frantic about her health and her behavior. Predictably, one result of this anxiety was to take the focus off Jean's smoking problem. In addition, the tension between Jean and George lessened as they came together in a common concern about Mary.

In beginning her treatment Mary met with a nutritionist regularly. All exercise and sports were curtailed, to be reinstated gradually as her weight rose. Individual sessions with Mary were directed to helping her deal with her feelings about eating and body image, as well as focusing on her own areas of concern. The overall focus in family therapy was to uncover the underlying tensions in the family.

Parents who are willing to explore their own sources of tension, either in their current lives or those tensions inherited from their families of origin (and they are usually connected), will greatly enhance the likelihood that their eating disordered child will recover. The work the parents do will have the effect of ladling stress out of the bucket, thereby freeing the whole family to deal with the more manageable issues it encounters during its life cycle.

If in therapy the parents can examine and perhaps modify the family's rules for expressing and dealing with stress, and if they are willing to experiment with airing and negotiating their own hurts and dissatisfactions, several outcomes can be predicted: (1) the tension and anxiety between the parents will diminish, and this in turn will lessen the tension that the child with the eating disorder feels; and (2) the parents, through this experience, will be in a better position to teach their child more constructive ways of dealing with her own anxiety and stress.

Because stress is transmitted through triangulating, I can assume that Mary is in one or more triangles in the family. No triangle can

work without the cooperation of all three people. One person may have more power than another, but all are participants. So if one person is enabled to act differently, the triangle will shift and we can work toward having the individuals in each twosome deal with their own issues.

The goal is to get the stress off Mary and back with the original twosome, so the two individuals involved can begin to deal with their own issues. Mary will then be free to deal with the tensions she should be working on, those involved with normal teenage development.

Although the therapist need not involve everyone in a family in the therapeutic process, doing so is clearly desirable and more efficient. Involving everyone does not mean that everyone is in the room each session. Some sessions include the whole family; some may include just the parents; some just the siblings; or some just the family member with the eating disorder. Some sessions include a mix of these groups. The family members with the most strength and flexibility are often those seen the most, since they have the greatest likelihood of effecting change in the family.

As Mary began to gain weight and became a lesser focus of anxiety, the family's attention again turned to Jean's smoking. Several changes occurred to shift the triangle. Mary learned that it was futile to try to control her mother's smoking. She and her father examined the loyalty conflict caused by their discussions regarding Jean, and they agreed to stop talking about Jean's smoking. As Jean began to understand her own family of origin's prohibition against discussing painful feelings and to explore the probable genesis of this rule, she began to see that this might not be a good rule for her family. Mary and her mother began to talk through some of their issues, expressing feelings instead of keeping them hidden.

So Mary and her father gained some distance, and Mary and her mother gained some closeness. The work that Mary's mother did in understanding her own family of origin and the permission given the family to express negative feelings made it possible for the parents to focus on their own issues which, not surprisingly, had more to do with unmet needs in the relationship than with Jean's smoking habit. The communication and negotiations that resulted siphoned off some of the anxiety in their relationship and in turn led to less

need to triangulate Mary into their problem. Mary's stress decreased, and she now had more emotional energy to go about the tasks of dealing with her peers and, in general, being a teenager. As the parents began to deal with their own life-cycle changes, they were able to be more reasonable with Mary and give her more age-appropriate responsibilities and freedoms. Experience in renegotiating family roles and rules paved the way for the older child's exit. The family now knew that they could adjust to a change in their relationship with her without losing her. Jean took a full-time job, which she loved, basically getting on with her life. George responded by working fewer hours, getting home for dinner more often, and taking on a more parental role with Mary. Mary's weight stabilized at 115.

OTHER MODES OF FAMILY THERAPY

The above example focused on recovery in a family where the person with the eating disorder was a child and in which the family therapist conducted all therapy sessions: some alone with the child, others with the parents, and still others with the entire family. This is often the most efficient way to work, but occasions arise when it is preferable for another therapist to see the adolescent individually while the family therapist works with the family unit. Using two therapists is best when the adolescent is extremely uncomfortable talking in individual sessions with a therapist who is also seeing her parents. In these cases the individual therapist and the family therapist need to maintain close contact, and all family members need to understand that the two therapists will be working in concert.

Eating disorders often develop in young persons during the family life-cycle stage of "launching." This is why we see such a high incidence of eating disorders among college students. Logistically, it may not be practical for family therapy to be the therapeutic focus for these young adults. The young adult should engage in therapy where she is living or where she is attending school. Parents are strongly urged to seek therapy on their own in order to support her efforts and not to unwittingly sabotage her. Arranging for occasional

family sessions during holidays or visits when the family is together is also helpful.

Family therapists often see adults with eating disorders as well. Just as in Mary's case, the focus is on reducing stress in the family. In treating an adult with an eating disorder, the focus is on family-of-origin issues. (Of course, concurrent focus must always be on alleviating the eating disorder symptom.) The person is "coached" to understand the events and rules in her family that led to unresolved stress (Carter and McGoldrick-Orfanidis 1976). She is then encouraged to approach her family of origin in a new manner, one designed to release her from the triangulated position. This work has been shown to be a powerful step toward improving relationships in her adult life. When the person with the eating disorder is married, therapy most often should include the spouse.

The work done by each member of the family of a person with an eating disorder will have a marked effect on the stress level in the family and the tension experienced by each family member. Having learned to approach issues with one another in a direct manner, stress will not build up and the family and each of its members will be free to carry out the primary business of supporting and nurturing one another's growth, development, and security.

References

Carter, B., and M. McGoldrick-Orfanidis. 1976. "Family Therapy with One Person." In P. J. Guerin Jr., ed., *Family Therapy: Theory and Practice*. New York: Gardner.

—, eds. 1989. *The Changing Family Life Cycle: A Framework for Family Therapy*. 2d ed. Boston: Allyn and Bacon.

Garner, D. M., P. E. Garfinkel, D. Schwartz, and M. Thompson. 1980. "Cultural Expectation of Thinness in Women." *Psychological Reports* 47:483–91.

Kerr, M. E., and M. Bowen. 1988. *Family Evaluation*. New York: Norton.

Keys, A., H. L. Taylor, and F. Grande. 1950. *The Biology of Human Starvation*. Minneapolis: University of Minnesota Press. In K. D. Brownell and J. P. Foreyt, eds., *Handbook of Eating Disorders*, p. 307. New York: Basic Books, 1986.

Orbach, S. 1982. *Fat Is a Feminist Issue II*. New York: Berkeley Books.
Richardson, R. W. 1984. *Family Ties That Bind*. Vancouver: Self-Counsel Press.
Root, M.P.P., P. Fallon, and W. N. Friedrich. 1986. *Bulimia: A Systems Approach to Treatment*. New York: Norton.
Siegel, M., J. Brisman, and M. Weinshel. 1988. *Surviving an Eating Disorder: New Perspectives for Families and Friends*. New York: Harper and Row.