

**Systemic Family Therapy for the Treatment of Anorexia Nervosa: A  
Movement beyond the Boundary of the Family, Towards Cultural  
Narratives.**

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## **Introduction**

Systemic family therapy involves the application of general systems theory principles to explain how pathology is triggered and maintained by dysfunctional patterns of communication within the family. Family therapy has been used to treat a variety of disorders including anorexia nervosa (AN).

The study of AN led Minuchin, Rosman and Baker (1978) to assert that the family context within which AN arises, consists of a specific process, typified by enmeshment, rigidity, over involvement and conflict avoidance, which develop around the symptoms of AN. This family process also interacts with a weakness in the individual and the individuals' role as an intermediary in cross-generational alliances. This contention led to the growth of structural family therapy, which aims to modify and restructure this particular family process.

However, with the therapeutic boundary being located at the family level, many family therapists have ignored what is beyond the family, which has resulted in a failure to contemplate the therapeutic significance of the cultural context within which families reside.

AN can be seen as an internalisation of our cultures fixation with thinness and attractiveness, therefore, contrary to family therapists, narrative therapists propose that we should not ascribe the cause of AN to families, but preferably move our focus towards the damaging effects of cultural narratives.

## **The Development of General Systems Theory**

Dissatisfactions with psychoanalytic approaches and other former therapies, in conjunction with the recent expansions in psychology, psychotherapy and communications, encouraged the growth of systemic therapy. Previous intrapsychic work focused on past issues that were supposedly rooted in the psyche, whilst ignoring the potential causal role of the person's present situation, which may involve interpersonal difficulties or disputes. Furthermore, psychoanalysts discovered that some patients were 'resistant' to change; they believed this resistance to be a result of underlying anxiety which the patient was protected from by the operation of defence mechanisms. However, psychoanalysis neglected the fact that change

could be brought about by modifications to the patients' relationships and interactions (Dallos and Draper, 2000).

From then on, advances in psychotherapy included the development of group therapy which exposed the significant therapeutic impact of assembling groups of people to talk about their problems. Furthermore, the emergence of child and marital guidance, which involved bringing families together, began to move the emphasis from individual treatments to more group and family-based approaches, which utilise the principles of general systems theory.

General systems theory involves the analysis of intricate, complex and sometimes disordered systems which are present in individuals, societies and science. The theory provides a holistic framework for comprehending how the separate elements of systems interact and how these interactions can bring about certain consequences. The theory stems from the work of Ludwig von Bertalanffy (1950) and has subsequently been developed by research findings in cybernetics, social science and biology.

General systems theory principles have been utilised in order to study the composition of human families in what is known as family systems theory. A family is thought of as a whole system, with each family member being an essential interdependent element of the greater whole. Therefore, the behaviour of any one family member is indicative of processes that occur within the whole family. As an element of the larger system, an individual family member can never strictly be independent of the larger system and can only be completely understood within the boundary of the family. In line with this concept, Minuchin (1974) suggested that "the whole family should be the target of therapeutic intervention" (page 130). Accordingly, family therapy focuses on the interactions that occur between members of the family, as opposed to individual behaviour.

The family is regarded as a subsystem within a social system. Parsons (1960) claims that each system within a social organisation is subordinate to the system directly above it, i.e. the individual is constrained by the family, as the family is constrained by society and so on. The Social hierarchy is sustained by socially delineated constraints of role and structure from above. Therefore, if a subsystem appears to be pathological, according to this view, it must be supposed that there is an intrinsic deficit in the system directly superordinate to

the abnormality, thus therapy aims to treat this superordinate structure. Therefore, if an individual displays abnormality or pathology, it is the family that must be treated.

Families are themselves made up of subsystems, for example, the sibling subsystem, the parent subsystem etc., and each of these are also separated by boundaries. Each subsystem has its own dependability and is directed by inherent rules and patterns of interaction. Boundaries are preserved by bonds between members of the subsystem. Bonds can maintain the psychological closeness of certain members, while preventing others from entering the subsystem. To maintain a healthy family system clear-cut boundaries between subsystems are essential, when these boundaries are not maintained a family will risk becoming disordered.

Furthermore, family systems are self-governing, homeostatic systems. Family members employ behaviours that maintain the stability and predictability of interactions between members of the family. Behaviours that could cause disequilibrium within the system are regularly managed via corrective feedback loops utilised by all family members. In healthy families, corrective and self regulating processes are adaptive. In dysfunctional families, corrective processes are rigid and interfere with the families' ability to adapt to the changing requirements of its members and environment.

One disorder that is commonly treated with family therapy is AN. The study of AN has been fundamental for the development of family therapy. Influential figures from the field of family therapy have considered the role of AN throughout the development of their work e.g. Minuchin, Rosman and Baker (1978), so much so, that AN may be seen as a paradigm for family therapy, just as hysteria acted as a paradigm for psychoanalysis (Garner and Garfinkel, 1997).

## **Anorexia Nervosa**

The National Institute of Clinical Excellence in the UK released guidelines (NICE, 2004) which describe AN as a disorder that causes individuals to be pre-occupied with maintaining a low weight, that is usually 15% below what is deemed to be a normal weight for that person. Younger individuals may be diagnosed with AN if they do not put on weight as expected as they grow, as they will be underweight without ever having lost weight.

This pre-occupation is caused by an obsession with body weight, interpreted either as a fear of getting “fat” or a quest for thinness. This ‘weight phobia’ is increasingly suggested to play a fundamental role in the continuation of AN and some believe this fear to be culture specific.

Eating disorders, namely AN and bulimia nervosa, are responsible for the highest levels of hospitalisation, treatment need, suicide attempts, and death, in comparison to all other psychiatric syndromes (Newman et al., 1996). Eating disorders are more common among women than men, therefore, this essay focuses only on the treatment of females with AN, however, it is important to note that men do suffer from the disorder.

The causes of AN are not known. There is a common consensus among researchers and clinicians that AN has numerous determinants (Garner, 1993), that materialise in a developmental order (Steiner and Lock, 1998). Onset typically transpires at some point in adolescence usually around the age of 17 (Hsu, 1990). There seems to be several environmental risk factors that contribute to the development of AN, such as peer group teasing (Fabian and Thompson, 1989), avoidance of family discussions, due to the anxiety that this causes (Larson, 1991) and acculturation to Western standards, usually experienced by immigrants (Soh, Touyz and Surgenor, 2006).

NICE 2004, reported that 1.6 million people in the UK are currently suffering with an eating disorder. Treatments for eating disorders vary. The most common treatments are cognitive behavioural therapy (e.g. Garner and Bemis, 1985, Pike et al., 2003), medical treatments (e.g. La Via, Gray and Kaye, 2000) and family therapy (e.g. Minuchin, Rosman and Baker, 1978). However, the UK Parliamentary Office of Science and Technology (POST, 2007) report that just under half of those diagnosed with AN will fully recover, whereas the rest will continue to suffer. Thus treatments may still be largely unsuccessful which indicates a need for further development of eating disorder treatments.

### **Family Therapy for the Treatment of Anorexia Nervosa and its Effectiveness**

The study of AN has led many to believe that the disorder is caused by problems within the family of the sufferer, therefore some have noted the potential importance of family

interventions, as opposed to individual treatments, for the management of AN (e.g. Minuchin, Rosman and Baker, 1978).

Minuchin et al. (1978) developed the 'psychosomatic family model' which became the foundation of family therapy for AN, in particular, it led to the development of structural family therapy. The model states that it is not just the behaviour of one individual that defines AN, but the interrelationship of all family members.

The model suggests that there is a particular family context which may be responsible for the manifestation of eating disorders, such as AN. Minuchin et al. (1978) claim that this family context consists of a specific process, typified by enmeshment, rigidity, over involvement and conflict avoidance, which grow around the symptoms of AN. This family process also interacts with a weakness in the individual and the individuals' role as an intermediary in cross-generational alliances. Thus the aim of structural family therapy is to modify and restructure this particular family process

*"In therapy, we look at the feedback processes by which the family members and the anorectic constrain and regulate each other's behaviour... (and) the transactions among family members that sustain the anorectic syndrome, and we work to change those transactions."* (Minuchin et al. 1978, page 22).

majority of studies imply that family therapy is most successful for younger individuals with only a short duration of AN. When therapy is completed, approximately 60-70% of patients will have recovered a normal body weight, however most (female patients) will not have recommenced menstruation. At follow up, usually 5 years post treatment, 75-90% will have completely recovered and only 10-15% will still be critically ill (Eisler, le Grange and Asen, 2003).

However, all accessible studies to date, suffer from small sample sizes and other methodological limitations, therefore, the results should be interpreted with caution. We can only confidently rely on the findings when replications with larger samples and randomised controlled trials are conducted. Additionally, there is not enough research comparing the effectiveness of family therapy with the effectiveness of other treatments,

such as cognitive and psychodynamic therapies, which are also used as clinical treatments (Eisler, 2005).

Furthermore, studies have failed to find a consistent family process or structure in families with an AN sufferer. Therefore, contrary to the predictions of the psychosomatic model, there isn't a specific type of family organisation that is exclusive to and constant among families affected with AN. There is a developing notion that families with a sufferer of AN are a diverse group with regards to socio-demographic features, the type of interactions within the family, the emotional atmosphere and the configuration of family patterns (Eisler, 1995). The fact that there is diversity among families with an anorexic sufferer, and that changes do not always occur in a predictable manner, inevitably provokes questions about the actual goals of effective family therapy and which fundamental processes the therapy aims to modify.

### **A Movement Away From the Family towards the Demands of a Wider Cultural Context**

As noted previously family therapy, despite being one of the most effective treatments for AN, still has its drawbacks and as noted, the therapy does not yield 100% success rates. AN still presents a major challenge to the mental health field, as it is still the number one cause of death, with regards to all other mental health illnesses (Newman et al., 1996).

Critiques concerning family therapy, as discussed previously, have led to a movement away from the reductionist notion that family organisation and interaction are the causes of AN, towards a contemporary and more extensive notion that it is the demands of a wider cultural context that play an important role in the manifestation and maintenance of AN. Despite claiming to be an open systems model, the psychosomatic model of AN and the general systems theory upon which it is based, both ignore the individual and the wider cultural context that equally influence the family patterns of interaction commonly observed by family therapists.

On the one hand, whilst family therapy has stretched our understanding of family systems, it has also led to a movement away from the psychology of the individual (Nichols, 1987). Some family structures are dysfunctional so much so, that they persistently resist efforts to



induce change; a problem which is commonly encountered by family therapists. The reason for this may be that whilst focusing on the interactions between members of a family as the origin of pathology, therapists may be ignoring the self within the system i.e. how problems may reflect not just family patterns, but the personalities of those within the system. In other words, therapeutic change brought about by modifying a families interactions, may not persist if the therapist does not get through to the individuals themselves.

On the other hand, for family therapy, the therapeutic boundary is situated at the family level, thus many family therapists have also ignored what is beyond the family system, which has resulted in a failure to contemplate the therapeutic significance of the cultural context within which individuals reside. The dynamics and processes of families may not be identical for all families with a sufferer of AN, as noted previously, as it may not be the organisation of the family which causes and maintains the anorectic symptoms. Instead it may be that sufferers of AN are all similarly affected by cultural values.

The theory of social construction suggests that the interactions and processes of families with a sufferer of AN may be necessitated by the requirements of the culture that the family resides in, as opposed to the idiosyncratic organisation of the family.

A focus on culture, may important when treating AN as cultural values have a particular role in the manifestation of AN. Schwartz and Barrett (1988) discuss how the historical notion that women occupy a secondary position in society can trigger AN. Women are implicitly expected to construct an impression of dependence. An impression, because while they are assumed to be secondary and dependent, in actual fact they are required to take care of themselves and others. AN may assist women to satisfy this societal command of subordination. Being anorectic can make women feel and look as if they are inadequate. However, being anorectic is very powerful, as the individual is the only one who can control their eating. Therefore AN is an implicit way of gaining control over ones life, whilst maintaining the status of a dependent person.

Another socio-cultural influence is the belief that the attractive female is thin. Society teaches many young girls, women and their families that achievement, relationships, confidence and life satisfaction are all acquired by achieving and maintaining thinness and attractiveness. As a result, this develops into a major life goal. This social ideal is particularly

prominent in Western societies; this has led to the identification of AN as a 'Western culture-bound syndrome'. North European Caucasian women have a greater extent of body dissatisfaction than their Asian and African-American equivalents and are also more prone to weight loss attempts (Altabe, 1998).

### **Narrative Therapy: An Alternative to Family Therapy, for the Treatment of Anorexia Nervosa**

The initial goal of family therapy was to observe maladaptive family interactions and behaviour, so that therapists could generate a change in these behaviours, with the intention that the system would then operate more efficiently. However, Watzlawick, Weakland and Fisch (1974, as cited in Angus and McLeod, 2004), delivered the idea of reframing to the field of family therapy, which is based on a theory that it is not the behaviour of another which causes an individual's behaviour, but rather the meaning or interpretation that one assigns to another's behaviour. This interpretation can restrict or broaden an individual's behaviour. Therefore, in order to bring about change within a family system, the therapist helps members of a family to reinterpret or alter the meaning which they assign to a situation. This notion of reframing can be interpreted as a step towards a more meaning-focused, narrative concept of therapy.

Narrative therapy is recently gaining more and more attention in the field of family therapy (e.g. White and Epston, 1990, Anderson and Goolishian, 2004), as a conversational art which records and carefully broadens the narrative accounts of patients. Narrative therapy is based on the idea that the narrative or storied form of language allows people to understand their lives.

A range of narratives are supplied by the culture within which a person resides. These stories are frequently internalised and utilised by people in order for them to comprehend their lives, however, culturally given stories are commonly restrictive, critical and blaming. No story is without uncertainty or conflicts, and stories frequently mask dynamics or power and influence. For instance, AN is linked with the severe effects of discourses about women, thinness and femininity in western culture. Narrative therapists collaborate with anorectic

women to confront these domineering social narratives in order to support them to reconceptualise how women resource or exploit their bodies (Brown, Weber and Ali, 2008).

A focal procedure of narrative therapy is the method of “externalisation”. Externalisation intends to detach the individual from the problem in order to generate other stories, this demonstrates that alternative stories exist, that dominant discourses do not always triumph and that rich alternatives can initiate the formation of reconstructed stories (Brown et al., 2008). These alternatives allow patients to detach themselves from their negative dominant story, which permits them to experience agency and provides them with the ability to intercede in their own lives and relationships (White and Epston 1990).

A book written by Maisel, Epston and Borden (2004), titled *“Biting the hand that starves you”*, discusses the utility of a narrative approach for AN and bulimia. They explain the process of externalisation as defining the “voice of anorexia” which denotes “the meanings that support and strengthen its regime” (page 21). They provide illustrations of the meanings that maintain and reinforce eating disorders, including feelings of shame, inadequacy and immorality and cultures and environments that stress success, competition, thinness, flawlessness and selflessness. Externalisation allows the internalised problem to be expressed outwardly. Thus, AN is not perceived as ‘living within’ the individual, nor is it viewed as an expression of control by the individual or a way of ‘gaining attention’. Furthermore, when anorexia is placed in society’s textual discourse, assigning blame to the individuals’ family is unnecessary.

### **A Comparison of Systemic Family Therapy and Narrative Therapy**

As narrative therapy, is relatively new to the field, systematic research is yet to be conducted, in order to ascertain the effectiveness of this new treatment, in comparison to family therapy. Nevertheless, it is possible to speculate the future utility of this new narrative phase of family therapy.

As a result of the shift towards narrative therapy, the family is no longer accused of being the definitive cause of pathology. Furthermore, therapists are now attending to the influence of culture. It may be argued that the narrative approach has widened the circle of responsibility for pathology. For instance, early intrapsychic therapists placed too much

emphasis on the individuals' inner world, so much so, that they neglected the family environment, subsequently family therapists counteracted that neglect by highlighting family processes and disregarding intrapsychic issues. However, family therapists became so committed to the significance of family dynamics that they too made a similar error which resulted in context neglect. Narrative therapy has rectified this problem by attending to the impact of cultural demands. However, narrative therapists should not necessarily prohibit analysis of family processes, just as family therapists should not have necessarily outlawed intrapsychic dynamics.

Minuchin (1998) points out that the importance of the family context has vanished with this new narrative phase of therapy. He discusses the detrimental effects this could have. The family is perceived as being an instrument, via which cultural principles are conveyed to the individual. therefore, the role of the therapist should be to free family members from the family's limiting narrative. Therefore, the systemic idea is lost if we neglect to observe this creation of meaning by family members.

In other words, the movement away from systemic principles, in order to account for the influence of environment and culture may be perceived as being illogical. By neglecting the family, the locus of context and culture, therapists have come back to an emphasis on individual human psychology, which is not only conventional, but does not match the components of post-modern theory that stress social relatedness. Thus narrative therapy has strengthened a singular voice that does not fully mirror the actuality of human experience.

However, Combs and Freedman (1998) advocates of the narrative approach state that young children learn about themselves in a variety of contexts, with the nuclear family being only one of these. When working with a young female sufferer of AN and her mother, Combs and Freedman noted that previous family therapy had led the mother to feel guilt and anguish, as she believed herself to be responsible for the illness. However, when they worked with the daughter alone, she revealed societal influences that had assisted the anorexia to take and maintain control over her. Contact with other AN sufferers who were fighting successfully against the illness, helped her on the road to recovery. Thus family therapy had not helped the daughter to do anything about her illness, whereas when other

relevant influences were drawn upon, the daughter was liberated and could see places in which her family presented relief from harmful societal views.

## **Future directions**

Future therapeutic techniques need not be limited to a focus on either the individual or the system. Rather the focus, in order to be incorporative and complete, must be on both the individual and the fundamental systems which the individual is a part of. In other words, the different techniques involved in family therapy and narrative therapy must be integrated to shape a new technique, which tackles an individual's problem with reference to the influence of the family and the larger, superordinate system, within which the individual resides.

Schwartz (1999) argues that showing partiality for a single level as the only or most influential level, restrains both therapists and patients alike. He describes the eating disordered patients that he has worked with as being noticeably subjugated by our cultures discourse, concerning women's value; however, they were also hindered by their inner voice that repeated the cultural values and by their family's compulsive and infatuated concerns with appearance. Thus as noted by Breunlin, Schwartz and MacKune-Karrer (1992) patients are rooted in interconnected constraints at each of these levels.

As noted by Tomm (1998) the family may be perceived as being a key mediator of cultural influences on the individual. In other words, culture may only have its effect via human interaction. Cultural implications may take on different meanings or different levels of significance as they are interpreted by the family. Therefore, the distinct characteristics, processes and patterns within a family may be of great consequence, as they might differentiate one family's value system from another's (Walsh, 1993).

Researchers such as Haworth-Hoeppner (2000) have highlighted the conjoint influence of cultural narratives and family processes on the development of eating disorders such as AN. Her findings showed that specific configurations of causal factors such as a "critical family environment, coercive parental control and a dominating discourse on weight in the household" (page 212) which specify both the influence of family dynamics and cultural demands, are responsible for eating pathology. Therefore, when faced with AN, therapists

must look at the impact of culture, with regards to the interaction that occurs in groups, such as the family, in order to successfully treat the illness.

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