The sibling relationships of bulimic women.

THE SIBLING RELATIONSHIPS OF BULIMIC WOMEN

A Dissertation Presented

by

Karen Gail Lewis

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KAREN GAIL LEWIS

Approved as to style and content by:

Grace Craig, Chairperson of Committee

Donald Carew, Member

Harold Raush, Member

George E. Urch, Acting Dean
School of Education

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ABSTRACT

THE SIBLING RELATIONSHIPS OF BULIMIC WOMEN

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KAREN GAIL LEWIS, B.A., BOSTON UNIVERSITY

M.S.S.S., BOSTON UNIVERSITY SCHOOL OF SOCIAL WORK

Ed.D., UNIVERSITY OF MASSACHUSETTS

Directed by: Professor Grace Craig

This study explores the role of bulimia in a woman's relationship with her siblings. While there is a growing body of literature on siblings and on bulimia, there is little written about the overlap between these two topics. This study is an attempt to fill that gap. Thirty-two women who had participated in an Intensive Treatment Program (ITP) for bulimia were the subjects. There were four groups of eight women each. Their comments about their sibling relationships were tracked through five components of the program: group therapy, multi-family therapy, family seminar, genograms, one year follow-up. All of their comments related to their siblings were transcribed from the video recordings of the therapies and the seminar. Each of the sibling comments was sorted into categories of common messages.

The study reports on all four ITP groups, and gives details about the women from one ITP group and their sibling relationships are given. Transcripts from their group therapy and multi-family therapy, and their comments

from the seminar on family roles are reported. Comments from a one year multi-family therapy follow-up questionnaire from women in several ITP groups are also reported.

Comments about siblings were categorized into seven types of communication messages: equalizing, dirty fighting, connecting, flagging, deflecting, separating, and peacemaking. Selection of the messages into the categories were checked by independent raters. There was a high consistency in the categorization. All but one woman had at least one message, and over half of them had either two or three types of messages for one or more siblings.

Three themes for understanding the use of bulimia in the sibling relationship are highlighted: bulimia as an indirect expression of affect to a sibling; as a means of getting out of a complementary role with a siblings, and as an expression of an immobilizing ambivalence in the sibling relationship. Although a descriptive study, the results suggest that sibling relationships are one important factor in the onset or maintainence of a woman's bulimia.

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CHAPTER I

INTRODUCTION

Throughout recorded history, there has been an interest in siblings. Illustrations of this can be found in Greek mythology, the Bible, and fairy tales. It is only in the current century that there has been emphasis on systematic attempts to study siblings. In the first two thirds of this century, the focus on sibling study was on ordinal position and the relationship of one's birth order to physical traits. By 1979, over 2000 articles had been published looking at the effects of the size of sibships, ordinal position and spacing on health, intelligence, achievement, and personality (Wagner, Schubert and Schubert, 1979). More recently, research has expanded to look at the mutual influence of siblings on their development, personality and life styles. Siblings have been studied from a variety of perspectives: large families (Bossard and Boll, 1956); marital relationships (Toman, 1969); development of siblings' self-identity (Schachter, Shore, Feldman-Rotman, Marquis and Campbell, 1976; Schachter, 1982); the mutual influence of younger and older siblings (Dunn and Kendrick, 1982; Dunn, 1985) and the relationship bonds among siblings (Bank and Kahn, 1982). While there has been increased interest in studying sibling relationships, there still has been little attention to the behaviors <u>within</u> the relationships.

It is well understood among family therapists that symptoms often are reflective of family interactions and are attempts at some form of communication within the family. Family therapy looks at the role of the symptom from a variety of perspectives: the symptom can serve as a mirror or deflector for unresolved parental issues (Madanes, 1981, 1984), as a homeostatic balance for the family (Selvini-Palazzoli, Boscolo, Cecchin, and Prata, 1978), as a multi-generational loyalty bond (Boszormenyi-Nagy and Spark, 1973), or as a misguided attempt at a solution to a problem (Watzlawick, Weakland, and Fisch, 1974). Most of the attention in the literature is directed to the triangular relationship of parents and the identified child, or to the whole family.

The symptom of bulimia has been considered by a few family therapists, working from a variety of family therapy schools. Schwartz, Barrett, and Saba (1984), structural/strategic family therapists, built upon the anorexic study of Minuchin, Rosman, and Baker (1978) and identified seven characteristics of the bulimic family. Todd (1985), who was one of the original team members of the Minuchin et al. (1978) study, added a broader community approach. Roberto (1986, 1986a, in press) does look at the siblings and bulimia, but from a transgenerational perspective. She sees the siblings as disengaged, trying

to de-identify with the bulimic sister. Root, Fallon, and Friedrich (1986) describe a general systemic approach to working with bulimia, within the context of today's cultural biases. Wooley and Lewis (1986; in press) present a comprehensive approach to treating bulimia that goes beyond just the family and today's cultural atmosphere. The focus of the symptom, in all of these writers, is on the nuclear and/or extended family dynamics. No one yet has written about the origin and maintenance of or cure for bulimia and the significance of the sibling relationship--within the family structure, but separate from the parental triangle or the transgenerational influences. This was a glaring absence given this researcher's clinical experience. Repeatedly, in this researcher's clinical practice, bulimic women made comments about their sisters being better than they in so many ways, but at least they--the patients--were thinner. Or these bulimic women sounded protective of a brother or sister, and later revealed that the sibling had been in constant trouble, while the bulimic woman had been the "perfect daughter." The plethora of such comments led to this study of the interface between the bulimia and sibling relations, and the potential messages the bulimia may be carrying for the bulimic woman to her brothers and sisters.

In reviewing the literature, it appeared that even the more recent family therapy studies were limited in their perspective. While there are studies about sibling

relationships and there are studies about bulimia as a symptom with significance within the family, there was a gap when it came to the significance of the bulimic symptom for the sibling subsystem. Therefore, the literature review in this study makes a leap between family therapists' work with siblings and their work with bulimia.

Overview of the Study

Purpose of the Study

This clinical presentation examines the sibling relationship for its relevance in the onset, the maintenance and the treatment of bulimia. The influence for onset may be direct, such as "My sister was bulimic and she taught me how to throw up," or it may be indirect, sending a covert message, such as "I have always been seen as the perfect child and my brother hated me; now I have a problem, so we are more alike." The sibling influence on the maintenance of bulimia and the treatment may be less overt, less conscious. It is further suggested that the bulimia may mask a covert communication message to one or more siblings.

Description of the Proposed Study

The University of Cincinnati Medical Center Eating Disorders Clinic was used as a bases for testing the above issues. Four of the Intensive Treatment Groups (ITP) were

studied; however, emphasis was not on the individual women in each group, but on the evolving process of their looking at sibling relationships in connection with their bulimia. (The program does not emphasize the sibling relationship any more than any other relationship. The treatment has a typical psychotherapeutic approach of hearing what the women say and then helping them to look at the multiple meanings of their comments.) Clinical data has been collected from several sources. Verbatim transcripts from group therapy and from multi-family therapy for each ITP group were used to look for sequences that reflected a sibling connection to the bulimia. In addition, results from one year follow-up questionnaires from both the bulimic women and from their siblings were studied, looking for specific references to siblings in relation to the bulimia or to the cure. When relevant, clinical observations have been added based on the women's family of origin genogram (i.e., the women drew their family tree identifying pre-specified personality characteristics for each person).

Significance of the Study

This study is significant in that it brings together two important themes--siblings and bulimia--that have yet to be studied for any mutual relationship. Thus far, there is little in the literature about the specific connection between siblings and bulimia. Family therapists do consider family relationships (although not siblings

specifically) important in bulimia, and family therapists have addressed the importance of the sibling relationship in general--not directly related to a specific behavioral problem. This study begins to bridge that gap.

Limitations of the Study

Clinical observations are used as a basis for this study. This type of study was chosen since, in a more quantitative pilot study, it became clear that counting the women's comments about their siblings was impossible. Most comments made by the bulimic women about their siblings were part of a sequence of comments between the woman and other group members and/or the therapists. Comments could not be easily identified as uninfluenced by others' input. Therefore, this current format was chosen; the sequence of comments from the several treatment modalities is presented, combined with results from one year follow-up questionnaires by the women and by their siblings. The goal of this study is not to produce direct evidence of causal connections between bulimia and sibling relationships. Rather, it looks at the process of the women making the connections during the treatment.

There are some obvious limitations to this study. Process data and process exploration are not to be taken as definitive fact or as representative of a general trend. Further, the sample is a self-selective one, since only those who have chosen to receive help in this particular

treatment program and who can afford to pay for the program are being studied. Another limiting factor is the possible bias of the researcher, who is one of the co-therapists for the group therapy and the multi-family therapy. Although efforts have been made not to unduly emphasize sibling relationships in the treatment, it is not possible to be completely neutral and objective.

Definitions of Bulimia

DSM III Description of Bulimia

There are many ways to describe bulimia. It has been defined by the American Psychological Association diagnostic criteria, and by its physiological, behavioral, and psychological factors. The Diagnostic and Statistical Manual, third edition (APA, 1980) sets the criteria for bulimia that are used as the official diagnosis for psychotherapists. However, the descriptions of the eating disorder are vague, incomplete and misleading. The DSM III does recognize that binge-eating is not normal, and that depression and self-criticism succeed a binge. The purge is not clearly described. The Manual lists 5 items for identifying bulimia:

A. Recurrent episodes of binge eating (rapid consumption of large amount of food in a discreet period of time, usually less than 2 hours).

B. At least three of the following:
(1) consumption of high caloric, easily ingested food during a binge, (2) inconspicious 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 fluctuations greater than 10 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.

(APA 1980, pp.69)

Unfortunately, these criteria do not distinguish between those bulimics who previously had been anorexic, those who only purge, those who only binge and those who eat compulsively. There are proposed changes for the next DSM (Root et al., 1986, p. 6) which will include 1) recurrent episodes of binge-eating occuring on an average of twice weekly for a duration of three months; and 2) use of a method of purging to counteract the binges, such as self-induced vomiting, laxative abuse, or rigorous dieting.

A Comprehensive Description of Bulimia

While most authors writing about bulimia would agree that the APA definition is too limiting and inaccurate (Root et al., 1986) there is general agreement about the psychological and physiological descriptions. The argument between the various theoretical schools is not over what is

included in the definition of bulimia, rather over what aspects are ignored. The description used in this study combines all components of bulimia--physiological and psychological as well as cultural, social and family. Bulimia consists of eating large amounts of food and then countering the ingested food through vomiting, laxatives, compulsive exercise, fasting, or starvation; these forms of purging may be used separately or together with diuretics, amphetamines, and diet pills. The secondary behavioral symptoms may include substance abuse, excessive use of caffeine, shoplifting, suicide attempts, moodiness and isolation.

The common psychological traits of bulimic women include the following: low self-esteem, striving for perfection, no clear self-identity, hypersensitivity to approval and criticism, flatness of affect, depression or moodiness, powerlessness, lack of genuine intimacy and fulfilling relationships, social isolation, obsession with food, weight and appearance. Bulimia can be an avoidance of facing feelings; it can be an excuse for not performing, not making decisions and not growing up.

In contrast to anorexia, the physiological symptoms of bulimia rarely cause death. The two ways in which bulimia can become fatal are through an imbalance of the electrolytes--loss of potassium--and through dehydration, both from excessive vomiting or laxative abuse. More

common symptoms include dental erosion and increased cavities; irregular menstrual cycles and amenorrhea that may or may not return to normal with weight gain. Excessive laxative use can cause loss of bowl elasticity and in extreme cases, may lead to the need for a colostomy. Other symptoms include cold intolerance, swollen parotid glands, painful digestion, and poor circulation in hands and feet which may appear redder or bluer when there is an increase in vomiting.

The general agreement in the literature for the onset of bulimia is around the time of high school graduation, representing the conflicts of leaving home and separation. Anorexia, by contrast is generally seen as a problem of early adolescence (Minuchin et al., 1978; Garner and Garfinkel, 1984; Schwartz et al., 1984; Root et al., 1986). However, the actual clinical examples belie this time frame. While the bulimic women reported in the literature are 16 years or older, most often they have been bulimic for a number of years before coming to the therapist´s attention. Curiously, this discrepancy is never addressed. Over half of the 150 women who have gone through the University of Cincinnati´s Intensive Treatment Program (ITP), said they began their bingeing and purging by age 15 or younger (Lewis, 1987a).

Root et al. (1986) say that the bulimic woman is often the youngest daughter. That also is contrary to data

from the ITP, where the birth order is about equal for oldest, middle, and youngest positions.

One interesting but unverified trend found in this researcher's clinical practice is that for some women the bulimia starts when an important sibling graduates from high school, leaves home for college, or marries.

Cultural, Social, and Family Factors

No one knows exactly how many women in this country are bulimic. Estimates of women who have experimented with bulimic behavior range from 20%-80%; rates are especially high among college age women (Hawkins and Clement, 1980; Halmi, Falk, and Schwartz, 1981; Olmsted and Garner, 1986). However, only about five percent of these women actually become bulimic to the extent of requiring professional help (Fairburn and Cooper, 1983). This study considers only the issues for bulimic women, not men, since more is known about women patients and there may be differences in the meanings of the bulimia for men.

According to a study done by Glamour Magazine (1984), there are indications that bulimia is increasing and not just better reported. The survey drew 33,000 reader responses, and although the sample is not random since it depends on its own readership, the size of the sample and the directions of results suggest the findings should be at least noted. In particular, 45% of those who would be

classified underweight by the Metropolitan Life Insurance Weight Chart--the model used by most doctors--felt "too fat." Comparison with a comparable study done by Psychology Today 11 years earlier, shows a worsening over time of women's dissatisfaction with their torsos, but not with other body parts (Wooley, 1986). The data also show that vomiting as a means of controlling weight gain is significantly higher for younger women: 11.8% for women over 40 years old; 8.2% for women 35-39 years old; 8.9% for women 30-34 years old; 11.2% for women 25-29 years old; 15.4% for women 20-24 years old; and 19.5% for females under 20 year of age (Glamour Magazine, 1984). This suggests that the increase is not just better detection, but that more women are resorting to bulimic behaviors.

There are a number of possible reasons for the increase in bulimia. Today's culture has placed a high premium on a thin body for women. The only other time that has been true in this century is during the period of 1920-1930, when large numbers of women entered the male working world (Silverstein, Peterson, and Perdue, 1986). Roles have changed today, as more girls feel compelled to model themselves after their fathers, not their mothers; values of caretaking and nurturance are being replaced by values of self-sufficiency and competition. The mother-homemaker role is no longer held in esteem. Daughters often attribute their mother's dissatisfaction in life to her body size--something that is remediable, "If only she were

thinner, she would be happier" (Wooley and Lewis, in press).

While society today offers women more professional options, there is still no support for a woman's expression of anger and power (Root et al., 1986). Desirable feminine characteristics--passivity and self-sacrifice--are contrary to requirements for healthy adult functioning (Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel 1970). "Women can be healthy and masculine or unhealthy and feminine; there is still not yet room to be feminine and healthy" (Root et al., 1986, pp. 25-26). A person without power is a frustrated and angry person, in need of some form of expression. When the anger is suppressed it transforms into depression. Inwardly expressed anger can be represented by the self-abuse of bingeing and purging "which function to establish some false, fleeting sense of control" (Root et al., 1986, p. 23).

Besides the emphasis on thinness, the changing roles for modern women, and their lack of power, there are other suspected factors related to the rise in bulimia. Wooley and Lewis (1986; in press) have suggested that women who become bulimic have experienced significant loss at some point in their lives. The loss may have been through the death of a sibling, parent, or grandparent, through a divorce, or through an emotional loss of the mother. The impact of the loss may be less from the absence of the

person than the emotional unavailability of mother (or father) during the grieving period. During this stressful time, the daughter may hesitate taking from what she sees as an already depleted supply of emotional availability; being a considerate and observant child, she will not make further demands on mother. Another possibility is that the child tries to make demands but finds a depleted mother.

Another recurring factor noted in the literature is the increase in the reporting, if not the occurrence, of sexual abuse. Wooley and Kearney-Cooke (1986) have found that 50% of the bulimic women in their program have been victims of childhood molestation, incest or rape. Root et al.'s study (1986) shows that 66% of bulimic women have been victimized through sexual or physical assult at some point prior to the onset of bulimia. The loss of power, the sense of shame and humiliation of the act, the women's assumption that it is their neediness that led to the abuse, and the lack of parental support after the abuse all lead to further their suppression of affect and their expression of needs. "The alternation of eating and purging constitutes a perfect metaphor for the emotional neediness and the repudiation of their needs" (Wooley and Lewis, in press).

C H A P T E R I I

LITERATURE REVIEW

This chapter presents the work of family therapists working with bulimia and the work of family therapists focusing on siblings, in an attempt to begin bridging the gap. Part I reviews articles and books that have expanded the information about sibling relationships from a systemic (interactional rather than an individual) perspective. Part II reviews the writings of family therapists on the specific symptom of bulimia. The remainder of the study attempts to interrelate the two topics--looking at the importance of sibling relationships in the development and maintenance of the bulimia.

Siblings from a Family Therapy Perspective

This part of the literature review discusses those family therapists who have contributed to a better understanding of the sibling influences: Minuchin (Minuchin, Montalvo, Guerney, Rosman, and Schumer, 1967; Minuchin, 1974; Minuchin and Fishman, 1981); Boszormenyi-Nagy (Boszormenyi-Nagy and Spark, 1973; Boszormenyi-Nagy and Ulrich, 1981; Boszormenyi-Nagy and Krasner, 1986); and Bank and Kahn (1982). There are other family therapists who have written about siblings in therapy: Allen (1977);

Coleman (1978, 1979, 1985); Eno (1985); Hamlin and Timberlake (1981); Lewis (1985, 1986a, 1986b, 1986c, 1987b, in press); Nichols (1986); Ramieri and Pratt (1978); Rosenberg (1980, in press). Unfortunately, their ideas have not yet become influential in the family therapy field.

Salvador Minuchin, originator of structural family therapy, was the first family therapist to describe the sibling subgroup as a separate, semi-autonomous system. In Families of the Slums (Minuchin, Montalvo, Guerney, Rosman, and Schumer, 1967) he studied families with one or more boys in the Wiltwyck School, a residential school for delinquent children. Through his investigation, he noted the significance of sibling relationships--separate from parental influence. For these multi-problem, low income children, he identified some general individual characteristics: action oriented, fast changes in mood; lack of self-observation; no expectation of being heard, but if heard, not expecting a response; attention getting through misbehavior; no conflict resolution; lack of verbal negotiating skills; limited skills in a three or more person exchange. In such a world, parents abdicate their executive role and the siblings have to provide for each other. They become each other's primary socializing agent, providing an anchor for each other when parents are not emotionally available; The older ones offer the younger ones nurturance, guidance, control; they set norms of

morality and they interpret rules and expectations of society to the younger children.

As he developed his model of therapy (Minuchin, 1974; Minuchin and Fishman, 1981) Minuchin incorporated his growing understanding of sibgroups--regardless of their socio-economic status. He described the sibling subsystem as the

> first social laboratory in which children can experiment with peer relationships. Within this context, children support, isolate, scapegoat and learn from each other. In the sibling world, children learn how to negotiate, cooperate, and compete. They learn how to make friends and allies, how to save face while submitting, and how to achieve recognition of their skills. They may take different positions in their jockeying with one another, and those positions, taken early in the sibling subgroup, can be significant in the subsequent course of their lives.
>
> (Minuchin, 1974, p. 59)

The boundary around siblings, separating them from parents, can provide them with a private space to practice developing social skills, to resolve fights, and to establish independent interests.

The task of structural family therapy is to rearrange the family structure. This usually means moving one of the children out of an alliance with one parent or from between the parents, re-empowering the parents with executive authority, and reuniting the children in a lower-hierarchical role in the family. For detriangulation to be successful, the child must be accepted by the other siblings. Often, though, the child has been so scape-

goated by the siblings, that re-entry is difficult. One way Minuchin reengages the child is to see all the children together, while parents silently watch from behind the one-way mirror or from outside the inner circle.

Ivan Boszormenyi-Nagy´s major contribution to family therapy is the concept of transgenerational loyalty binds (Boszormenyi-Nagy and Spark, 1973; Boszormenyi-Nagy and Ulrich, 1981; Boszormenyi-Nagy and Krasner, 1986). While he does not focus on the sibling relationship, he was the first to write about the intrinsic relational expectations and obligations, the concepts of justice and injustice, the balance and imbalance of the intergenerational bookkeeping ledger. With an understanding of the interplay of the individual and multigenerational issues, the roles and interactions of all the siblings will make more sense.

> Loyalty commitments are like invisible but strong fibers which hold together complex pieces of relationship "behavior" in families....To understand the functions of a group of people, nothing is more crucial than to know who are bound together in loyalty and what loyalty means for them. Each person maintains a bookkeeping of his perception of the balances of past, present, and future give-and-take. What has been "invested" into the system through availability and what has been withdrawn in the form of support received or one´s exploitative use of the others remains written into the invisible accounts of obligations.
>
> (Boszormenyi-Nagy and Spark, 1973, pp. 39-40)

Each family has a destiny ledger that records the accumulation of merit the parents have earned by giving to their child. There are two ethical components to this ledger. One is the legacy, the debt that is carried over

from the past; the other is the accumulation of merit. The legacy may be, for example, that males are successful and daughters are not; or that the oldest child is caring, the second child is lazy. Whatever the family myths, they are passed down through the generations.

A parent earns credit, accumulates merit, just by virtue of being the child's parent. The more genuine the parenting, the more credit the parent earns. The more trustworthy the parent, the larger the child's debt. A self-sacrificing, overprotecting parent stores a large amount on the credit side of the ledger, but since the parent will not allow direct return payment, the child's debit column becomes large. In addition to direct repayment, debts can also be repaid by maintaining loyalty to the family relational values and obligations. These values, however, are not necessarily overt nor positive.

> The individual may pay legacy obligations only in the way he or she has been taught to pay, e.g., the beaten child may become the child-beating parent....In that case, the person's hands may, indeed, be tied by the chains of destiny. (Boszormenyi-Nagy and Ulrich, 1981, p. 164)

As the child reaches adulthood, repayment is due. The adult child either repays the debt directly to the parent, through the next generation, or the child postpones or avoids repayment. A direct repayment plan is through living the shared values--be that love and trust, or child abuse. This is most obvious in families that repeat their own history, such as three generations of women unhappily

married to alcoholic men. As each daughter of each generation repeats the pattern, she repays the early obligation through remaining loyal to her mother and her father--by not creating a family situation different (albeit better) than their own.

A second way to repay the debt to parents is through redepositing the obligations with the next generation. For some adult children, it is easy to be a devoted, caring, trustworthy parent.

> The inherent right and merit of a helpless infant to be cared for is probably the strongest factor to counterbalance his parent's guilt over loosening his own life-long filial obligations. Thus, the rewards of parenthood include...the exoneration from guilt of disloyalty through fulfillment of an obligation. Parenthood is a unique chance to pay reparation for internally sensed guilt over imputed disloyalty.
> (Boszormenyi-Nagy and Spark, 1973, p. 48)

If the debt is not paid, if the child feels more obligation than can be repaid, the ledger gets imbalanced. The guilt grows as the debt grows. When an adult child is not making repayment, that person's child may become symptomatic, with the dysfunctional behavior expressing attempts at rebalancing the debt by repaying the parent's debt.

While Boszormenyi-Nagy makes only passing reference to the importance of the family loyalties for siblings, the implications should be apparent. Children's behaviors are dictated to some extent by the family roles that have been historically ascribed. Frequently, two siblings are

assigned complementary roles: one child is designated as the good, competent one and the other gets the extreme opposite roles, the sick and incompetent one. Family projections of behaviors and roles are dealt without fairness. Some children are the recipients of positive legacies, some of the negative ones. Their behaviors are, to some extent, dependent on each other's roles in the family and the historical roles from both parents' lineage. Without understanding the historical precedences of the roles and the transgenerational myths and ledger accounts, a child's misbehavior may be entirely misleading.

Bank and Kahn's book Sibling Bond (1982) is perhaps the major addition to the literature on siblings. The book explores the emotional connections, rivalries, and loyalties between siblings; their disappointments, guilt, and passions that evolve from early childhood through old age. It also looks at parental influence on the sibling relationship.

Sibling Bond reports on the authors' eight year study of sibling relationships (toddlers to old age). It is based on detailed notes from their clinical practice and on open-ended and focused conversations with siblings at different ages, ethnic background and social class. Subjects were volunteers from colleges and professional organizations. In all, the authors assessed 250 sibling sets, audiotaping or videotaping sessions with almost 100

of them. About 1/5 of the interviews were conducted in the siblings' homes. Some of the interviews were two or three hours long over a six week period; about 1/3 of the sibling sets were followed for more than a year.

Bank and Kahn (1982) say the sibling bond can be either positive or negative, but it is at least reassuringly predictable. Siblings' feelings, behaviors, and self-image can be intricately related to their sense of each other and their identity.

A key concept is sibling access--their mutual emotional impact. Siblings with a high level of access are usually close in age; they may attend the same school, share the same friends, clothes, interests, bedroom. High access siblings have had intense involvement with each other and have been important in each other's development. Low access siblings are usually more than eight years apart, with little shared time, space, or history, having had little importance in each other's development.

Three situations predictably leading to the development of the sibling bond are high access between siblings, the need for meaningful personal identity, or insufficient parental influence.

> When other relationships--with parents, children, or spouse--are emotionally fulfilling, the sibling bond will be weaker and less important. Thus, when other relationships cannot be relied upon, intense sibling relationships are activated. The results of this intensification can be helpful or harmful, depending upon the circumstances of each

> family, the personalities of the children, and the actions and attitudes of parents.
> (Bank and Kahn, 1982, p. 19)

Bank and Kahn (1982) agree with Minuchin et al. (1967) that siblings provide a practice ground for the real world--for testing roles, trying on personality and relationship styles. Over time siblings establish a power hierarchy for resolving conflict. It is within the safety of the family--with peers who will not leave--that children learn workable rules for fighting. Fighting can be creative and growth producing where children can learn fairness and self-regulation. On the other hand, negative fighting often develops out of parent's misguided, but best intentions of helping. When parents interfere with the fighting out of their own fear of conflict, the children are prevented from experiencing their own resolution.

The importance of peers in the development of the adolescent identity has long been acknowledged (Blos, 1941; Erikson, 1950). Siblings, however, are influential before adolescence. Bank and Kahn (1982) believe the sibling attachment starts very early, is instinctual and mutual. The older child is not far removed from the life experiences of the younger, while the younger one uses the older one(s) as a transitional object--between the initial attachment to mother and the outside world of peers. In adolescence, siblings emphasize their similarities and/or their distinctions, as a means of creating their own identities. Further, since only one person can "occupy a

certain psychological space in a family at any one time" (Bank and Kahn, 1982, p.23), children will each develop a separate, unique role, that does not overlap with another sibling's role. For example, if one child is known as "the brain," the others must find identities not related to intelligence. This is true with all roles, whether positive or negative. This is similar to Boszormenyi-Nagy's idea of complementary roles (Boszormenyi-Nagy and Spark, 1973).

Sibling relationships are not static; they change throughout the life cycle, depending on life circumstances. However, in general they are stronger during childhood and adolescence, are less intense when the siblings are leaving home and establishing a separate identity, and resurge in adulthood in times of stress (e.g., parents' illness or death) and again in old age. If, in childhood, siblings had a positive relationship, the changed relationship during young adulthood is bound to create a loss: a gradual loss has a less negative and lasting effect, while a sudden change may cause permanent damage to their relationship. One way of dealing with the change--for the older and the younger siblings--is to freeze their images of each other from when they were younger, that is, to hold on to caricatures--either positive or negative. While this protects against the loss as the children develop, frozen images carried into adulthood prevent an

acknowledgement of a changed style and personality and can block a growing, evolving relationship.

In adult years, even if siblings have little contact, they still carry inside them some parts of each other that to some extent influences their choice of friendships, marital partners, employment, and life style. Bank and Kahn (1982) suggest that unresolved sibling issues reappear in the marriage, as husband and wife recreate their earlier sibling battles, treating each other as reproductions of their frozen sibling images. And these issues appear again in their children's relationships. Often when parents are stuck in dealing with their children it is because they see their own sibling conflicts reflected in their children and respond accordingly. Through their children, they attempt either to repeat or amend their own sibling relationships. Conversely, when siblings are in unresolvable conflict, they may be mirroring their parents' unresolved sibling issues (Lewis, 1985).

Summary

This section has discussed three major influences among family therapists in the exploration of the importance of the sibling subgroup: Minuchin uses siblings in structurally rebalancing families (Minuchin et al., 1967; Minuchin, 1974); Boszormenyi-Nagy indirectly influenced the work with siblings through his theories of transgenerational loyalties (Boszormenyi-Nagy and Spark,

1973; Boszormenyi-Nagy and Ulrich, 1981; Boszormenyi-Nagy and Krasner, 1986); Bank and Kahn (1982), influenced by the other two, actually studied siblings' relationships across the life cycle. Boszormenyi-Nagy and Minuchin show little mutual influence, perhaps because their early work occurred around the same time. Minuchin was putting problem children's behavior into context of their nuclear families while Boszormeny-Nagy was putting the nuclear family into it's historical context. Bank and Kahn, as part of a later generation, acknowledge their debt to both of the others, as they explore in depth the impact siblings have on each other. Although Bank and Kahn have a chapter on treatment and cite one example of anorexic twins (1982, pp. 41-47), their work primarily is contextual and theoretical, not dealing directly with treatment of eating disorders.

Family Therapy's Perspective on Bulimia

The first family therapist to develop a specific understanding for families with an eating disorder was Minuchin (Minuchin, Rosman and Baker, 1978). Psychosomatic Families is reviewed here even though it specifically deals with anorexia since so much of the later writings about bulimia expanded from the Minuchin et al.'s original concepts. This section will follow the development of family therapists' work with bulimia. The first part will look at the way family therapists have attempted to classify the type of families that produce a bulimic daughter. The second part will look at the specific treatment models each therapist uses. Included are the writings of Minuchin, Rosman, and Baker (1978); Schwartz, Barrett, and Saba (1984); Roberto, (1986a, 1986b, in press); and Root, Fallon and Friedrich, (1986).

Family Classifications

Family therapists have attempted to classify the types of families that produce a daughter with an eating disorder. Minuchin et al. (1978), referring to anorexic families, identify four characteristics of psychosomatic families. The first is enmeshment, where families are extremely overinvolved and where the boundaries between individual members and between hierarchies are blurred. In an enmeshed family, "changes within one family member or in the relationship between two members reverberate throughout

the system" (p. 30). Enmeshment can exist on all levels within the family--the whole family, subsystems, and individual members. The second characteristic is the overprotectiveness of family members. "Family members are hypersensitive to signs of distress, cueing the approach of dangerous levels of tension or conflict" (p. 31). The children too, exhibit signs of overprotectiveness in their efforts to protect the family from distress through development of a symptom.

The third characteristic of psychosomatic families is their rigidity. These families lack flexibility around change. They have difficulty in times of change and at transitions in individual and family developmental stages. They are "highly vulnerable to external events, such as changes in occupation or loss of kin. Almost any outside event may overload their dysfunctional coping mechanisms, precipitating illness" (p. 31). The fourth characteristic is avoidance of conflict and lack of conflict resolution. These families tend to deny that problems exist within the family, and in particular, within the marriage. Some families openly disagree, but the issues get blurred or side-stepped, never resolved.

There are three ways these parents tend to avoid open conflict. In triangulation, one child (the anorexic) is caught between the parents, each wanting the child as an ally against the other. A parent/child coalition exists

when one parent is openly allied with the child, and the other parent is excluded. The third method of dealing with conflict is detouring, where parents look as if united, and their conflicts get redirected through their mutual concern about or anger at the child.

Schwartz and his colleagues (1984) believe the four characteristics of anorexic families (Minuchin et al., 1978) also fit bulimic families. However, they have identified three other general traits of the bulimic family: "isolation, consciousness of appearances, and a special meaning attached to food and eating" (p.282). Using these characteristics, they have identified three types of bulimic families: the all-American, the ethnic and the mixed family. They believe there is conflict within the family, or between the family and society, around cultural expectations. The all-American family places high value on appearance and success; their politeness hides the extreme underlying competitiveness. Ethnic families are also isolated, enmeshed, and appearance-conscious. But their purpose is different; rather than wanting the American Dream, they want to maintain the traditional roles and values. Fatness is less of an issue than the significance of the food itself, which defines relationships--expressions of anger or love. While the isolation of all-American families is from competitiveness, with ethnic families it stems from distrust of non-family. In mixed families, some members

are protecting the old values and ethos, while others are pushing for more acculturation. In bulimic families with parents of different values, the daughter is caught in the middle. Bulimia may be a way not to choose sides.

Making no reference to families' ethnicity, Root et al. (1986) identify three types of bulimic families: the perfect, the overprotective, and the chaotic family. The first two are relatively similar to the enmeshed and overprotective families mentioned by Minuchin et al. (1978). Both have rigid boundaries around the family, but weak ones around individual members; members are intensely loyal to each other, with a lack of separate identities. The emphasis for the perfect family is their outward appearance; the issues for the overprotective family are lack of hierarchical boundaries and overprotection which hinders the development of autonomy. Whereas negative feelings cannot be expressed in the perfect family because it is not proper, in the overprotective family, the concern is hurting someone's feelings. In the perfect family, bulimia provides a form of acceptable rebellion; in the overprotective family, bulimia is a means of gaining personal space.

Examples of the covert family message for the perfect family are

> United we stand; divided we fall.
> What will others think?
> If you can't show a happy face, don't show your face at all.
>
> (Root et al., 1986, p. 86)

This is in contrast to the covert messages of the overprotective family:

> All for one, one for all.
> Noone is good enough for my daughter.
> There´s no place like home.
> (Root et al., 1986, p. 101)

While the first two families are similar to those described by Schwartz et al. (1984) and Minuchin et al. (1978), the third family type, the chaotic family, is similar to substance-abusing families. There is inconsistency of rules, disengagement of family members, unavailable parents, and overt expression of anger; one or more family members often have been victimized. The uncontrolled expression of anger, the pseudo-autonomy, and the emotional cut-offs are in striking contrast to the other family types. The role of the bulimic daughter is to smooth conflict and to divert abuse from mother or siblings towards herself. These families´ covert messages include

> Every person for him or herself.
> The only person you can count on is yourself.
> When the going gets tough, the tough get going.
> (Root et al., 1986, p. 117)

The function of bulimia in chaotic families is to give the woman nurturance and affection she lacks in her family, to safely express her anger, and to numb her against the emotional distance from others. Bulimia is a way to continue the family´s abuse cycle while disassociating from the reality of the family´s chaos. It provides predictability in an otherwise unpredictable family environment.

Each of the above mentioned clinicians delineates separate parameters of bulimia.

> This is part of bulimia's fascination. There is something for everyone, from the researchers who like symptoms they can count on to the philosophers who like to analyze society. Consequently, there are increasing numbers of "blind" men and women, ourselves included, who are feeling different sections of the bulimic "elephant" and giving very different descriptions of what it feels like.
>
> (Schwartz et al. 1984, p. 280)

Each of the above views are viable, yet each is only a partial reality, not the whole picture.

Treatment

Many family therapists are working with families with a bulimic member; yet only a few have developed a specific model intertwining systems theory with the unique aspects of eating disordered families. Minuchin (Minuchin et al., 1978) was first to develop a therapeutic model for eating disorder families. In the study of psychosomatic families, Minuchin and colleagues worked with 50 anorexic families, where the identified patient ranged from 9 to 21 years of age, with 60% being 13-16 years old. Treatment averaged 6 months. Eighty-six percent of these girls were cured both medically and psychologically. A medical cure was when eating and body weight returned to normal. If the girl stopped eating after treatment, she was not considered "cured." A clinical cure included good adjustment to the family, school, peers, and outside activities. These

results were based on follow-up contact with family and pediatricians from one and a half to seven years later.

The families were seen in a Structured Diagnostic Interview, where the parents engaged in an argument while the child observed behind the one-way mirror and then later participated in the argument. Throughout the session, the anorexic child's physiological response was monitored--while she watched her parents in conflict, and when she joined them in the conflict. Strikingly, the child's presence decreased the parents' level of conflict; however, this was at the expense of her own physiological measurement which continued to increase. Even after the interview, when the conflict remained unresolved, the child maintained the same high level.

There is a mutual influence between the anorexic symptom and the family's functioning. In order to stop the anorexia, the girl must eat, and the family patterns must change. The general goal of therapy is to disrupt the family's dysfunctional patterns of relating, and to provide them with more flexibility in dealing with stressful situations. The therapist begins by focusing on the life-threatening symptom and then moves to family interactional patterns that support the symptom.

From this family systems perspective, treatment challenges the family's reality and the four

characteristics of enmeshment, overprotection, rigidity and conflict avoidance. The family's view of the problem must be changed from the child is sick and parents are helpless, to parents and daughter are caught in a control battle. This reframing will highlight the conflict of autonomy and control, and can be used to initiate a crisis within the family. A high intensity crisis is needed because the rigid family structure will attempt to maintain its status quo against any mild interventions. The most well known crisis inducing intervention is the family lunch sessions. Here the therapist tells each parent separately to try to get the daughter to eat because her life depends on it. As each one fails, the therapist points out the girl's competence in defeating the parents and then reframes her behavior as voluntary disobedience, not involuntary illness. The changed view of reality gives parents alternative interactional responses.

The therapist working with the psychosomatic family must assume leadership, establish rules and control interactions. Minuchin's own style is dramatic, using heavy-handed therapeutic interventions. He does utilize the sibling subsystem; unfortunately, he does not describe the power of this group separate from the rest of the family. As mentioned earlier, his clinical examples often show how he maneuvers the siblings to help unbalance and/or rebalance the whole family system.

Schwartz, Barrett, and Saba (1984) also work from a structural family therapy perspective. They studied 30 of the 100 normal-weight bulimics they had seen over four years. The average length of therapy was 33 sessions, over a nine month period. The study consisted of analyzing videotapes of therapy sessions, from which they identified the three family types mentioned earlier: 33% of the families they studied were "clearly 'ethnic' families; about 40% showed a blend of ethnic and American values ('mixed' families); and about 27% were clearly 'all-American' families" (p. 283).

Their treatment goal is to help families recognize their own strengths, which will enable them to develop as yet undeveloped parts of themselves. By restructuring the context of families' expectations and experiences, new aspects of themselves become clearer or evolve. The family then will have more options for thinking and seeing situations differently. Insight, behavior modification and medication are not needed because family members carry within themselves the necessary ingredients for change, for becoming more competent.

Schwartz et al. (1984) have also been influenced by the strategic family therapy school (Haley, 1976; Madanes, 1981, 1984) that recognizes the family's ambivalence towards change. Therefore, they restrain the family from changing too fast, cautioning against negative consequences of changes, identifying the protective aspects of the

symptom, and predicting recurrence of the symptom. Strategic symptoms are used only with those families whose fear of change is so great as to inhibit their growth. Therapy will "alternate between advocating changes and warning against the same changes, in rhythm with the oscillation of the ambivalence of the family or patient" (p. 289).

Contrary to Minuchin et al. (1978), they do not consider cure as a total abstinence from bingeing and purging; it is a decrease in importance of food and weight and (as for Minuchin) an improvement in social and family relationships. Schwartz et al.'s goal is for women to see bingeing "not as a dreaded enemy, but either as a signal that something needs to be taken care of, or as an old friend with whom they like to keep in touch" (Schwartz et al., 1984, p. 290).

Treatment occurs in three stages: creating a context for change, challenging the family's dysfunctional patterns and expanding their view of alternative behaviors, and then consolidating the change the family has made. Treatment modalities include individual and family therapy with backup medical support. Working directly with the bulimia does not occur until the woman has begun to differentiate from her family of origin, usually in Stage 2. Treatment progresses along a continuum of 1) motivating the family and patient for differentiation; 2) guiding the

differentiation; 3) targeting the symptom; and 4) inoculating the system against relapse. Whereas Minuchin and colleagues (1978) use a strong leadership style, Schwartz and his colleagues rely on the strategic one-down position, congratulating the family for their work, down-playing the therapists' role in the changes.

Outcome results (Schwartz et al., 1984) indicate that the women regain control over the symptoms. Change occurs in family relationships, in life goals or career, and in the woman's behavior in extrafamilial relationships. The mean length of follow-up is 16 months (1-42 months). Sixty-six percent were nearly always in control, with one or no episodes per month. The families that had the least change were not those with the most severe symptoms, but those where the bulimic daughter still lived at home, since--the authors say--it is more difficult for the bulimic woman to give up the bingeing and purging while still living at home.

Schwartz et al. (1984) do acknowledge the importance of the sibling subgroup, mentioning two sibling issues. There is extreme competitiveness between the siblings related to their need for parental approval. Sibling conflict resolution is impossible since parents interfere with siblings' fights. The second issue is the "well" siblings' resentment of the control and attention the bulimic sister gets. The authors note that the well siblings lose if the bulimic woman gets well. Unfortunately

they do not say how. What seems a fairly obvious competition--sisters' weight--is not mentioned.

Roberto (1986a, 1986b, in press) has been influenced by the symbolic-experiential model of Whitaker (Whitaker and Keith, 1981) and the transgenerational model of Boszormenyi-Nagy (Boszormenyi-Nagy and Spark, 1973; Boszormenyi-Nagy and Ulrich, 1981; Boszormenyi-Nagy and Krasner, 1986). The bulimic woman has "a valued role in the history of the family over the span of time....Roles, values, and customs in these traditional, rigid families are inherited like a metaphorical coat of arms, and are called 'family legacies'" (Roberto, 1986a, p. 232). Like Schwartz (Schwartz et al., 1984), Roberto makes no effort to have the bingeing and purging stop, reframing the behavior as being in line with the family legacy, handed down through the generations. The family's belief system espouses a spirit of self-sacrifice, appearance-consciousness and symbolic meanings of food and eating. Early in therapy, through use of a genogram (McGoldrick and Gerson, 1985), information is gathered about family losses in this and prior generations. These losses can be through death, chronic illness, expatriation, separation from nuclear family, or financial ruin.

> Surviving grandparents, and the second generation show a determination to make up for, cover over, and overcome these losses at all costs although discussion of these may be forbidden. Attractiveness, physical fitness, and general appearance-consciouness become enmeshed with the familial

> mandate to "get ahead," "do the family proud," and "be a model wife/daughter/mother."
> (Roberto, 1986a, p. 233)

These more discussable issues become a smokescreen for the unspoken issues of family loss. Often, unresolved losses of earlier generations are compensated for in the current one. For example, the bulimic woman whose parents were raised in the deprivation of the depression, will make sure her children have money and security, even if she must stay with her abusive husband. The most potentially lethal belief system in these families is the filial loyalty, self-sacrifice for the benefit of the extended family.

While Roberto (1986a, 1986b, in press) does not rely on the strategic one-down position that Schwartz et al. (1984) use, she does apply the initial caution against change. She explains that the symptoms are "following in the 'hallowed traditions' of the extended family," (1986a, p. 234) and are their adaptation to crisis. As the connection to the past is clarified in therapy, the family will give up their old structure out of recognization of the legacies, or they will continue with the old structure, fully aware of the interlocking issues.

Roberto (1986a) describes her three Stage treatment. The early phase is called a Fact-Finding Mission. Here the therapist gathers data about the family's belief system, exploring the extended family history, and constructing the family legacy. "The bulimic child is defined as representing the epitome of familial beliefs. S/he is

elevated from the status of victim to that of dutiful but doomed child fulfilling the family legacy" (p. 13). In the mid phase, The Problem is Expanded, the extended family is brought in for a consultation. The purpose of this meeting is to heighten the family's awareness of the mixed allegiances, and to air their doubts about change. The family is cautioned against the consequences of change--breaking the legacies, and signs of regression are positively connoted.

During the late phase, the Price Tag for Change, the family considers the practical consequences of change and discusses alternative solutions. The different generations are seen separately in therapy. As change is happening, individual work with the bulimic woman can be helpful since family legacies are now brought to awareness and are no longer inhibiting. The woman now has no need to defend her sick role in the family.

Roberto's (in press) main thesis about siblings is that they attempt to deidentify with the bulimic sister, remaining emotionally distant from her. They ally themselves with parents or stay removed from the family, fearful of being drawn into family conflict. They see their sister drawn into the family vortex, but do not offer her help for fear of being sucked back inside themselves.

Root et al. (1986) have been influenced, as have Schwartz et al. (1984) by both Minuchin's structural family

therapy (Minuchin, 1974; Minuchin and Fishman, 1981), and the strategic school of family therapists (Haley, 1976; Madanes, 1981, 1984). In addition, they rely on Boszormenyi-Nagy´s concepts of transgenerational issues (Boszormenyi-Nagy and Spark, 1973; Boszormenyi-Nagy and Ulrich, 1981; Boszormenyi-Nagy and Krasner, 1986). During a three session consultation, they look for boundary issues (What do you know about your daughter´s symptoms?); conflict resolution (Who gets hurt the most when Mom is angry?); family protection or projection (Is there anybody in the family you grew up in whom your daughter reminds you of? or What significant things were happening when this daughter was born?), and the likelihood of change. They give families their Guidelines for Family Members Who Want to Help a Family Member Recover from an Eating Disorder. This offers, among other things, recommendations for avoiding the inevitable power struggles, discouraging dieting, and setting appropriate limits on the woman´s behavior.

The therapist sees the woman individually during this assessment period--to join with her and to establish boundaries to help her begin to separate from her family. Unlike the other authors reviewed so far, Root et al. (1986) mention inquiring about physical and/or sexual abuse.

The overriding goals in the family therapy are to help the family reorganize so there is no longer a need for the

bulimic symptom, and to help the woman make an appropriate adjustment to the next developmental stage--leaving home. Other goals may include helping the family set appropriate boundaries, regulating the emotional distance between parents and the bulimic woman, altering rigid or destructive family rules, expressing anger and other communications in a more direct manner, grieving an unresolved loss.

While the authors do not use organized treatment stages, they demonstrate a treatment of each of the three types of bulimic families--perfect, overprotective, and chaotic. They show how they

> determined the typology of each family, how we decided whom to involve in treatment, how we formulated our hypotheses about the functions of the bulimia in the system, what risks the family faced by attempting change, the obstacles to treatment, and the development of and rationale for the interventions used.
>
> (Root et al. 1986, p. 225)

It is unfortunate that despite their acclaimed feminist attention to the cultural impact on women and the resulting distorted body image effects, Root et al. (1986) have ignored these issues in their clinical examples, not showing how they are addressed in therapy. In addition, there is no mention at all of the impact of the siblings on the development or the maintenance of bulimia.

Summary

Family therapists who have a specific model for bulimia have been influenced by 1) Minuchin´s structural

family therapy (Minuchin, 1974; Minuchin and Fishman, 1981) and with his treatment of anorexic families (Minuchin et al., 1978); 2) the strategic school of family therapy (Haley, 1976, and Madanes, 1981; 1984); and 3) Boszormenyi-Nagy´s transgenerational family therapy (Boszormenyi-Nagy and Spark, 1973; Boszormenyi-Nagy and Ulrich, 1981; Boszormenyi-Nagy and Krasner, 1986). The strategic influence is used to deal with the family´s homeostatic resistance to change, while the transgenerational influence is used to help understand the resistance.

Minuchin et al. (1978) address the eating earlier in treatment than Schwartz et al. (1984) and Roberto (1986a, 1986b, in press) who first look for some family restructuring. Schwartz et al. (1984) and Root et al. (1986) will see the woman individually early in treatment, while Minuchin et al. (1978) do not mention individual therapy, and Roberto (1986a, 1986b, in press) uses it as a later step. Root et al. (1986) and Roberto (1986a, 1986b, in press) mention other treatment methods such as group or couple therapy. Root et al. (1986) are the only ones who refer to the issues of physical and sexual abuse, although estimates run as high as 60% among bulimic women.

Sibling involvement in the onset or maintenance of bulimia is significantly lacking. While Minuchin does use the sibling subgroup as a tool for provoking change within the family (Minuchin et al. 1967; Minuchin, 1974; Minuchin

and Fishman, 1981), he does not mention it in his work with psychosomatic families (Minuchin et al., 1978). Schwartz et al. (1984) make passing reference to siblings' importance but do not address the potential for a direct connection between siblings and bulimia. While Roberto (1986a, 1986b, in press) does directly address the siblings, she sees them as trying to distance themselves from the bulimic sister because of family patterns and historical legacies. She does not see a connection between the siblings and bulimia that is separate from the whole family's issues.

CHAPTER III

METHODS

Family therapists believe that presenting problems are a form of communication within the family. There have been many attempts to understand bulimia--from the family, social, cultural, psychological and physiological perspectives. One aspect that has been overlooked thus far is the possible significance of the sibling relationship. This study looks at the interface between bulimia and the bulimic woman's siblings; it looks at the sibling influence in the onset, maintenance and treatment of bulimia; it looks at the function of the symptom in the messages that are communicated between a woman who is bulimic and one or more of her siblings. A message may reflect feelings towards the sibling that can not be expressed more directly, or it may reflect a concern about one or more of her siblings.

Design of the Study

This present study is a clinical presentation supported by sample statements from bulimic women about the meaning of their bulimia in relation to their siblings. Statements have been taken from the treatment and from one year follow-up comments. There is no comparison with bulimic women in another type of treatment program, and there is no pre- or post-testing of the women.

The University of Cincinnati Medical Center Eating Disorders Clinic was chosen since it is one of the oldest such clinics in America, established 16 years ago. It also has a solid research component that is already looking at the interface of bulimia with family, cultural, social, physiological, and body image factors. This study builds on that base of data addressing the potential sibling influence in bulimia.

In the program, the bulimic women begin to understand the issues underlying their becoming and staying bulimic. The program, more fully described in the next section, includes: five weekly group therapy sessions, four weekly body image therapy sessions and five weekly food restructuring groups; two individual therapy sessions each week; 13 hours of didactic seminars during the four weeks; and a two day multi-family therapy group. Aspects covered in the treatment are: improved eating and the physiological implications around bingeing/purging and/or fasting; cultural, social and family influences; and individual psychological factors.

Several methods have been used to study the sibling relationship to bulimia. Videotapes of the group therapy sessions were reviewed, looking for clinical sequences that showed a woman talking about her siblings. Since one comment rarely demonstrates any significant connection, all series of comments between a woman and the other group

members and/or the therapists were noted. Videotapes of the multi-family therapy sessions were reviewed, again looking for sequences of sentences that related to the bulimia and the women´s siblings. The third method used involved the bulimic women´s responses to a one year follow-up questionnaire; only aspects related to siblings were studied here. Also noted were the siblings´ responses to a one-year follow-up questionnaire asking about their impressions of the multi-family therapy and if there has been any change in their relationship with the bulimic woman. The fifth method used, when applicable, involved the genograms the women drew of their family of origin, noting pre-specified personality characteristics. These five methods were then used to assess sibling influence in the development, maintenance and treatment of bulimia.

Setting and Subjects

Seven times a year, the University of Cincinnati Medical Center runs The Intensive Treatment Program for Bulimic Women (ITP). This is a four week residential, non-hospital-based program where eight women live in nearby hotel apartments with kitchens. The women are totally responsible for their food purchasing, preparation and intake. There is no monitoring of their eating, purging, fasting, or exercising. The program does not control their eating; instead, it helps them understand why they have

eaten as they have. The intent is to remove the control battle over food in order to prepare them for their everyday life after the program, when they will not have someone monitoring their eating behavior.

The women attend the clinic 6-8 hours each week day, participating in a variety of therapies. Each week, there are 10 hours of group therapy, 8 hours of body image therapy, 2-3 hours of individual therapy, and 10 hours of food group. In the food group, the women look at their daily eating patterns to understand what triggers the binges, how to increase tolerance for "forbidden" foods, and how to avoid bingeing and purging. There are 13 hours of didactic seminars during the program covering topics such as weight set point, cultural influence, assertiveness training, and a family of origin seminar that deals with family roles. In addition, there is a two day multi-family therapy attended by the extended families of all participants--parents, siblings, grandparents, etc.

There is minimal advertising for the program--occasional ads in a few college newspapers. Patients hear about the program from prior patients; from seeing a staff member on television, hearing the staff on the radio, or reading about the program in a national magazine; or by getting a referral from their own therapist who knows one of the staff, has heard the staff present at a conference, or read articles or book chapters written by the staff,

describing the program. Staff refer some of their own patients.

There are few specific criteria for admission. The women must be willing to try to eat three meals a day, and they must want to come of their own accord. Anyone currently alcoholic or drug addicted is not admitted. The women who attend the Intensive Treatment Program (ITP) must be at least 18 years of age and must have graduated from high school--since they will be living without supervision. There is no upper age limit; however, the oldest women to have attended the ITP so far have been in their early forties. The literature says bulimic women are from upwardly mobile middle class white families, and are bright and ambitious. While that may be true in the literature, this program is encountering a growing number of non-white and working class women. There is no cultural or religious predominance, and there have been a small number of identical twins. The women have come from all over the United States as well as from Wales, Canada, and the Philippines. All have at least finished high school, and by far, most have at least started if not finished college.

The program is expensive ($4500 for 4 weeks) which may be a delimiting factor. Insurance companies will pay whatever their regular coverage is for out-patient psychotherapy, which usually ranges from 50% to 80% of the total cost. Some women, with limited or no insurance

coverage, have had to borrow money from friends and relatives or have taken a bank loan to pay for the treatment. Women do not go to this extent unless they are feeling really desperate for help. Some feel so desperate that they drop out of school, or take a leave of absence from school or work in order to participate in this program. Most of the women who do participate have had multiple prior therapies and hospitalizations for their bulimia.

Procedure

The Intensive Treatment Program (ITP) administers a number of tests as part of a variety of research projects, including outcome studies. Published one year follow-up data is available (Wooley and Kearney-Cooke, 1986; Wooley and Lewis, in press).

However, there is no research on the specific treatment components or treatment issues. This project uses three of the treatment components--group therapy, the multi-family therapy, and the family seminar, together with one year follow-up questionnaires for both the bulimic woman and the siblings to assess what, if any, meanings of the bulima or messages are connected to the siblings through the bulimia.

This study combines clinical observation and quantitative data based on reviewing videotapes. Videotapes of the group therapy and the multi-family

therapy of four ITP's have been analyzed, noting all sequences that include the bulimic woman talking to or about her siblings. The daily group therapy sessions (16 per group) and the multi-family therapy (2 full days, totaling about 18 hours) have been videotaped by a stationary camera in the room, without a technician. The women and family members knew the camera and microphone were being used, as most of the components of the program are routinely videotaped. They understood that all information from each of their groups was shared with all staff.

The five components of the study are described below.

1. Group therapy.

Two therapists co-lead the daily two-hour group. These are non-structured sessions, where the women raise whatever issues they choose. The content may be directly related to family issues, or it may be about feelings activated by specific incidents or interactions with one or more of the other women in the program. Group therapists generally believe that people recreate their interactional patterns, taking "their family with them when they go out in the world" (Burrors, 1981, p. 4). Therefore the women begin to react to each other in ways that are often reflective of their relationship style with their siblings. Bank and Kahn (1982) refer to this as sibling transference. Initially the issue is worked through with the group member but then it is taken back to its presumed origin with the sibling. For example, Mary is angry at Carol for talking down to

her. Carol in return is angry that Mary acts so helpless. First the women try to resolve the issue with each other, then they are asked if they have felt that way before. This invariably brings up earlier (or continuing) sibling stresses. Often the women will raise the sibling connection themselves, "You make me so mad; you are just like my brother; he thinks he knows it all."

2. Multi-family therapy group.

This two day meeting includes the extended families of all eight women. There may be as many as 50 people present. There are three goals to this meeting; in successive order, they are: a) to teach family members the basic facts about bulimia and the recovery process; b) to assess the family's style of relating, to observe family myths and distortions; c) to effect change by making something different happen within the room, blocking the family's typical behavioral responses, hence, opening doors for new behavioral exchanges (Wooley and Lewis, 1987). For the purpose of this study, comments and interactions between siblings during the second and third stage will be reported.

3. Family seminar.

During one of the seminars, the women discuss family roles and are asked to identify the roles for themselves and each of their siblings. The seminar also has the women identify the sibling they are most worried about and the one who may likely become the focus of the family's concern if the bulimic woman gets well. The lists of roles have

been recorded and are coordinated with the rest of the information gathered about the women.

4. Genograms.

This is a family tree that depicts at least three generations of all family members on both sides of the family (McGoldrick and Gerson, 1985). Added to the genogram is the color coding (Lewis, submitted) which uses colors to identify a series of personality traits often associated with bulimia. The women are asked, using a different color for each trait, to identify which trait fits which family member. The assemblage of colors on the genogram show patterns in personality style and traits. It also shows opposites, such as Peace At All Costs and Explosive Anger. When useful, patterns between the siblings have been noted.

5. Multi-family therapy follow-up questionnaires.

These are routine questionnaires sent out to everyone who attended the multi-family therapy one year after completion of the program. Any comments, observations, or insights about the sibling relationship or its connection to the bulimia have been noted. The questionnaire responses are used only informally for possible suggestions, since the return rate is very poor, with returns from only some siblings from only some families. (Not returning the follow-up data is not necessarily an indication of dissatisfaction with the program nor with a sister's return to bulimia. The program often hears about

sister's return to bulimia. The program often hears about or from graduates who are doing quite well, despite the fact that they and their family did not return the questionnaires.)

Data Anaylsis

The data were analyzed in the following manner. All video sequences relating to the bulimic woman and her siblings--from both the group therapy (36 hours from each of the four groups) and the multi-family therapy group (19 hours from each of the four groups)--were reviewed. Sequences that show the bulimic woman's awareness of a sibling message attached to the bulimia were transcribed in order to scrutinize associative patterns. The intent was to look for comments that might show the bulimia carrying a particular message to one or more siblings. These verbal sequences were then sorted into categories, describing the type of sibling communication. An example of a type of category is equalizing. An equalizing statement indicates the woman feels her bulima is a means of balancing the sibling relationship, so that the sibling(s) is not in a superior or inferior position to the bulimic woman. A statement that fits into the connecting category reflects the bulimic woman's effort to connect or reconnect with an emotionally distant sibling.

The one year follow-up questionnaires from both the siblings and the bulimic woman were read looking for meanings related to the categories found from the tapes. With such a small return on the follow-up questionnaires, the results are not statistically meaningful. Instead, they are used to report what happens within some families. There has been no specific effort to cross check comments from the same woman from the video tapes and from the follow-up questionnaires.

Potential for Bias

A basic bias is the format of the treatment program. By virtue of the residential nature, where the women live together and spend much of their day together, siblings issues are more likely to come to the fore. A second major bias is the duel role of the researcher. Since the principle investigator is also co-therapist of the group therapy and the multi-family therapy, there is a possibility that vested interest may have swayed the discussions or blurred interpretations of conversational sequences. Bulimic women are frequently "people pleasers" which increases the likelihood that they accept an interpretation from the therapist about a sibling connection to the bulimia just to please the therapist. Because of this, this therapist/researcher frequently asked if her comments were being accepted out of politeness.

While that is not a foolproof method, it does give the women permission to say yes if it is true. Every effort was made, however, to contain any bias.

C H A P T E R I V

CLINICAL FINDINGS

This chapter will describe and summarize the findings from this study of the function of bulimia in sibling relationships. Four groups of eight women, a total of thirty-two women, have been followed through five components of the Intensive Treatment Program (ITP) for bulimia--the daily group therapy, the two day multi-family therapy, the family seminar, the genograms, and the follow-ups. The group and family therapy were videotaped and then transcribed. All comments about their siblings were noted and then categorized into communication message groups.

The first half of this chapter describes the women and the five components in the study. While the data have been collected on all four groups, only one of the ITP groups (hereafter called ITP #1) is described in detail. By highlighting just one of the ITP groups, the eight women can more easily be identified and tracked through the various aspects of the program.

The second half of this chapter describes and analyzes the findings for the study. This includes the selection process for the message categories, the eight categories, the reliability check, the analysis of the messages and the multiple messages. The information in this half of the chapter derives from all four ITP groups.

Introduction

Discerning the meaning of a symptom is a difficult task, given that most symptoms probably have more than one meaning. Furthermore, symptoms are often a behavioral representation of a covert or unconscious feeling. This study attempted to translate the covert to the overt. For some bulimic women, this entailed following their growing awareness of a connection between their bulimia and their siblings; for others, it entailed reporting on their already conscious awareness of the connection.

There is no pure way to study the women's comments since their comments are likely to have been influenced by conversations with therapists and with the other women in the program. Some of the women initiated the topic of their brother or sister themselves; for other women, the therapist or another group member raised the topic. Some started the program talking about their awareness of the importance of their sibling in their bulimia. For others there was an acumulative effect, i.e., early in the program they thought less about their siblings but later in the program they had a more complex understanding of the relationship with siblings. Therefore, any statement about the women's awareness of any connection between their siblings and their bulimia must be taken with an

acknowledgement of the above factors. It should be remembered that sibling comments represent, for most women, only a small part of their total communication during the four week program. There were, however, a few women for whom siblings were a major issue during the treatment.

The Subjects

Four groups of eight women, totalling thirty-two women, were followed through four ITP groups. These women were 18 years or older, ranging from age 18-38 years. The length of time of their bulimia ranged from 2-18 years. Some had had previous psychotherapy, others had not. The only homogeneity of the women were their experience with bulimia and their seeking help in this program. The main criteria for acceptance into the program were their wanting to get better and their ability to pay the fee. Those women who were actively alcoholic or drug dependent, dangerously underweight or acutely psychotic were screened out and referred for psychotherapy (or a minimum weight gain) prior to acceptance in the program.

The eight women in ITP #1 are listed in Table 1 along with their siblings. Below are descriptions of each of these women. Identifying information about them has been disguised. None of them knew each other prior to the ITP. The data come from what the women shared about

TABLE 1

Women in ITP #1 and Their Siblings

ITP Women	Siblings
Terry, 22 years	Jim, 29 Lorraine, 28 Dan, 26 Lucy, 25 Billy, 19
Hing Sue, 19 years	Lua, 16
Ruth, 20 years	Bob, 23
Vera, 38 years	Hal, 36
Beverly, 18 years	Phil, 19
Monique, 23 years	Sayra, 25 Harry, 17 (step-brother)
Lois, 21 years	Gail, 19
Linda, 19 years	Sally, 23

themselves in their application to the program and in the daily group therapy (described in the next section). Only family information relevant to their sibling relationship is given. Information about the parents is given only if relevant to the siblings. The program is actually more comprehensive than described in this study; however, only aspects that offered information about the sibling relationship were included here.

The Women

1. Terry, a senior in college, has been bulimic for 6 years. Since both parents were alcoholic, Lorraine, the oldest sibling, acted as the "surrogate mother." Terry adored Lorraine for coming to all of her activities--hockey games, school plays, etc. As she got older, though, Terry resented Lorraine's attempts to mother her. Terry's second sister, Lucy had a reputation in the family for always having a problem. As an adult, Lucy developed agoraphobia, requiring her (she decided) to move back into her parents' home. It was during this period that Terry discovered Lucy was bulimic; her own bulimia started shortly after Lucy's stopped.

   Terry's second brother, Dan, had always been interested in photography and had hoped when he graduated, to work for a film company. However, he did not get any job offers, and hence sold real estate. Terry too, was interested in photograpy. Now in her senior year, she has a wonderful internship offer for the summer and next year with a local film company. She talked at length about her conflict that she would be more successful than Dan. She really wanted to take the position, but she was worried Dan would feel badly that he had not been able to make it in the field. Her other two brothers--her oldest and her youngest--are not very successful professionally and are somewhat withdrawn from the family.

   Terry talked frequently of feeling out of place--that she was the one with the most potential, the one

who had had the most success so far. If she graduated college and took this position, she would be leaving her family behind. She tied that in with her concern that she was the only one who was left to take care of her alcoholic parents, since the others had all moved out.

2. Hing Sue, a freshman at an Ivy League college, has been bulimic for the past 6 years. Her parents, both professionals, were born in China but they met and married here in the States. They keep in touch with their homeland and live within the Chinese community in their home town. The children though, have developed within the American culture.

Hing Sue was considered the smart and responsible child in the family; her verbal ability, at such a young age, stood out in contrast to her younger sister's shyness. One day Hing Sue said, "Being sick was my way to get out of being the responsible one."

When the issue of siblings arose one day in Group, Hing Sue said she did not have any problems with her sister. They were close and got along fine. Someone said that her sister must have negative feelings about having a bulimic sister for 6 years. A little later Hing Sue says, "I think I now understand. If someone sapped as much of my parents' attention and energy as I have for so long, I'd be angry too. Lua must be angry at me and just never shows it."

In preparing for inviting the family members to the multi-family therapy, Hing Sue role-played being her sister when Hing Sue invites her. Saying what she thinks Lua believes but would never say outloud, Hing Sue says, "I can't come. I know it's important to you but it is going to dredge up things I don't want to think about, things that are better left alone."

3. Ruth, a junior in college, has been bulimic for 3 years. She says she is very close with her father and describes herself as his showpiece. She spoke angrily of her brother who had always ignored her. She suspected it was because she was the favorite child and he always got in trouble. She had adored him, had looked up to him when she was younger. He though, would have nothing to do with her. "I always did more than I had to to get him to accept me, and I was still turned down. I do that with other people too, I just noticed." Since she has been bulimic, "Bob seems to care about me; he actually calls me every once in a while to see how my bulimia is....If I get better, I may lose him again; he won't have to be concerned about

me." Ruth is afraid to grow up, to let go of her dependence on her parents, particularly her father ("I´m not sure though, who is holding on to whom"). She is jealous of Bob who is now independent. "He got out, and I´m still stuck here."

Despite this, Ruth says she does not want to invite Bob to the multi-family therapy because, "We´re not that close. I don´t think he´s relevant to my bulimia. He´s been out of the house for 5 years and I don´t see him as part of my problem."

4. Vera, bulimic for 8 years, has been married to Vic for 18 years; they have two teenage daughters. Vera is a real estate broker. While she has been weight obsessed since she was 10 years old, her actual bulimia did not start until she and her husband moved 150 miles from her parents and her brother.

It upsets Vera that Hal openly states he hates their parents. When their mother dies, she worries he will feel tremendous guilt. Vera refuses to invite her brother to the multi-family therapy. "He really does hate my mother. He doesn´t like to be around her. If he has to be around her, he won´t speak to her. Those strong, negative feelings will not be of help to me here." Vera at different times says she is terribly bothered by his hatred, and she is not affected by his feelings towards their mother.

5. Beverly, a freshman in college, has been bulimic for 4 years. Curiously, she omitted Phil´s name from the list of siblings on the application. Two years ago she was in a car accident in which her best friend was killed.

It was two weeks into the program before Beverly acknowledged any problems except her weight. Then she began talking about the accident. Although not the driver, she had felt responsible for the crash and felt guilty that she had lived. Before the accident, Beverly had been a good natured child and was smarter than her brother; she had been the "family´s hope." Phil had been a rowdy teenager. After the accident, from which she suffered minor brain damage, she became moody; her bulimia became worse and her grades plummeted. Phil´s behavior changed too. He became "the perfect child and the one that turned out well."

Beverly was beautiful and her appearance was particularly important to her. When asked about a large scar on her leg she tried to brush it off. When pressed, she said when she was 12 years old, Phil had

kicked her leaving this scar, six inches long by one inch wide. "I can't show anyone my legs....He knows how angry I am. It's not that big a deal; it was just a typical fight." Someone asked if they fight any more. "No, not since we don't live together." Someone else pointed out the similarity that she has chosen boyfriends who physically abuse her.

6. Monique, in a New York acting school, has been bulimic for 5 years. Her parents quarreled a lot before and after their divorce 18 years ago. Mother remarried and had another child when Monique was 6 years old. Her mother and step-father are now in the process of divorce. Monique has had erratic contact with her father who lives out of state.

Her sister, Sayra, who had been a difficult teenager, also lives in New York, pursuing a career as a singer. Although talented, she keeps failing. Talking about her sister's career, Monique says, "When things are going well, it's as if she wants them to fail." Monique's half brother, Harry, was so involved with drugs and misbehavior, he was sent to a special school. Monique is the only child who has not "messed up," but she cannot get herself to succeed either. "I always yearned for a good relationship with Sayra and Harry. I always felt discounted by Sayra...like I just wasn't an important part of her life."

7. Lois, a college junior, has been bulimic for 5 years. It was her younger sister Gail who taught her how to eat and then throw up. Lois believes Gail is still bulimic, although she denies it.

Lois was always the sensitive child; her feelings were easily hurt. She was the good, quiet child, while Gail was more outgoing and rebellious. Lois said that while growing up, "Gail always started the fights. I would complain to mommy, and Gail got punished, but she deserved it....I could have killed her." But she never fought back. "I would go in my room and make Gail have to break the silence between us." While they still fight when together, when at their separate colleges, they talk on the phone at least twice a week. "Gail was always getting mom's and dad's attention when we were younger, because she was always in trouble. But now I have all their attention. I think she may actually be involved with drugs, but they don't have time to worry about her now."

Lois is more attractive than Gail and is sexually active. She wonders if her promiscuity is related to the fact that Gail rarely dates and has never had sex.

She is aware that her bulimia is worse when she and Gail are both at home and just before she goes out with a man. With all of her men, Lois has never had a serious relationship.

In talking about the upcoming multi-family therapy, Lois says, "My bulimia at least gives me mommy´s and dad´s attention. I don´t want Gail there. I don´t mind her coming separately....Gail is the most important person to me--more than mommy and dad. I think if I were to die, it would be harder for Gail. But I hate her and I shouldn´t. She´s the most important person to me, my best friend."

8. Linda, a college sophomore, has been bulimic for 3 years. She first became conscious of her weight when her older sister, Sally, teased her about the size of her legs. Mother and Sally often dieted together; Linda never did. One time she did join them. Sally said Linda "could never do it; right then and there I decided to prove her wrong. I quit eating completely." The vomiting started soon afterwards. Yet, when Linda decided to get help for the bulimia, "I knew I couldn´t get it on my own [so] I called my sister."

Sally was the emotional one, the perfect child, and parents´ favorite according to Linda. Linda developed herself into the tough child. "I never had a chance." They used to fight and "I got blamed for everything because I was four years younger." Linda believed "The only way I got attention in the family was to be a total bitch or to mope around the house."

In preparing for inviting Sally to the multi-family therapy, Linda talks to an empty chair, representing Sally. "You always make it to everyone else´s birthday. You never make it to mine....You never give time to me; you never talk to me....I feel like I´m a nuisance because I was born."

The descriptions of these women will make it easier to follow them through the rest of the components of the study. The next section will describe each component with examples from one or more of these women.

Components of The Study

This section describes the five components of the treatment program that are part of this study. Group therapy and the two day multi-family therapy are described and actual transcriptions are reported. The two hour family seminar was also transcribed and information about family roles are reported here. Genograms are described and examples are given showing how sibling related issues can be found in the transgenerational characteristics. Also included are comments from the one year multi-family therapy follow-up questionnaire sent to the bulimic women and their families. However, only those from the women and their siblings are reported here.

Group Therapy

Group therapy meets for two hours, Monday through Friday for four weeks. All the women attend and it is led by two co-therapists. The theoretical orientation is an eclectic one, combining aspects of psychodynamic, gestalt, and family systems theory. While talking is the primary mode, occasionally the women are asked to participate in an expressive therapy technique, such as movement or art. They may be asked to perform tasks during the session or for homework. Gestalt techniques, such as talking to empty chairs representing important people in their lives, are also used.

The therapists are sometimes directive, sometimes non-directive. They are sometimes confrontive, sometimes supportive. The role of the therapist is determined by the stage of the group and the needs of the particular member at any given point in therapy. Therapeutic transference issues are not emphasized but are dealt with when necessary. This is important since the women see the therapists in other contexts outside of the group therapy.

The women are encouraged to take responsibility for what issues are raised in the group; the leaders rarely initiate the discussion. The women ask for time or just begin talking about an important issue. This may be from their childhood or it may be a current issue; it may be related to family members, friends, other program participants, or therapists.

The topic of siblings is only raised by the therapists if it is clinically appropriate, e.g., to help bring to consciousness the metaphorical allusions to a sibling. The therapists and the group members may raise the issue of a sibling.

Sometimes the statements about siblings are isolated sentences or paragraphs. Other times the statements are long discussions that may continue erratically for several days. Below are some brief statements the women made about their siblings during the group therapy. Later, there is an example of a group exercise devoted to the issue of siblings.

Before knowing about the bulimia, we hardly ever saw or talked to each other. Now my brother calls frequently to see how I am doing.

My mother and Bob were on the phone constantly talking about what to do about me once I dropped out of college and stopped going out. They hadn't talked for ages before all this started.

Sally was always a better student and musician than I. I hated that she always did so well; she was so stuck up. Now at least she talks to me, worrying how I am doing.

What else would we talk about if we didn't talk about food or dieting?

These comments have been isolated from their context. Therefore, to give a fuller example of the multiple sibling impact, a segment of an exercise from group therapy will be reported. This excerpt shows how close to consciousness is the sibling influence. The exercise, which occurred during the second week of the program, was designed after Ruth talked about how much she wanted to become independent from her family. She asked Monique how she had managed to separate from her family, how had she become so self-sufficient and independent. She said Monique had "it all together." Monique said it was not true. "Remember, I'm in this program, too." However, Ruth persisted in refusing to hear Monique. The therapist then asked Ruth, "Are you also talking to your brother, by chance?" Ruth says, "She does remind me of Bob sometimes."

The women are instructed to start a role play. Ruth is to talk to Monique as if she were talking to her brother.

Monique is told to respond as herself, as if Ruth were talking to her directly.

Ruth: How did you do it?

Monique: You can do it. I don't know what I did.

Ruth: I hate the fact that you could break away, and I can't. Everyone else does, but I can't find the strength to do it.

Monique: You aren't even trying. There is so much of you that doesn't even want to.

Therapist to Ruth: Are you angry at him because he got away?

Ruth (slipping back to talking <u>about</u> her brother): He calls me and he feels so goddamn confident and I hate him for that. I hate him because he has the strength to do it and I don't. (Reverting to talking <u>to</u> him, via Monique) You have the strength to do it, I don't. I don't want to be so <u>loved</u> anymore. I need your help; I hate you.

Therapist instructs her to try saying more about both feelings, her hate and her need for him. Then she talks about how she needs his help in breaking away from her father.

Ruth: I need you to be with me, to help me break away. (Switching to talking about brother) He thinks it's stupid that I feel like this. He did it and I can't. (Getting angry) He's a tough one; I'm not, but I want to be. I wish I didn't have anything growing up. I mean, I wish he had all the attention.

The therapist asks Ruth to pretend to be her brother, and to talk as she thinks he may actually feel about her.

Ruth (as her brother): I hate you Ruth because you got it all when you were young. And I suffered for so many years being depressed; now it's my turn. Maybe you deserve it in a way. You just took and took from our parents and never thought how I felt. So I had to toughen up. You deserve to be weak.

The therapist has all eight of the women divide themselves into two groups: those who got too much from parents and those who did not get enough from parents. Four women--Lois, Hing Sue, Beverly, and Vera--decide neither side fits for them, and they sit out the exercise. On the Have side are Ruth and Terry; on the Have Not side are Linda and Monique. The instructions are for each woman to talk to the other side as if it were her sibling. There was an initial awkwardness, but the affect soon overcame the discomfort. They are told to start with Ruth's original question.

Ruth: I want you to tell me how you did it.

Monique: I acted as if I were so together.

Ruth: You are together.

Monique: That's obviously a lie. I fooled a lot of people on that one. If there's something that you need, and you feel like you're not going to get it, the safest way is to pretty much make yourself believe that you don't want it anyway. Sour grapes. Who needs it?

Linda: Do you know what it's like trying to compete with you, Miss Straight A student? Hunky dory little good girl who does everything mommy and daddy want her to do. Sits there and does everything fine.

Ruth (shouting): Do you know what it's like to be dependent? You don't!

(The tension is mounting on both sides as the recriminations get close to the long pent up feelings.)

Linda: You didn't bend over backwards for mom and dad? Lying through your teeth so you'd make them happy? I told them how I really felt but you never did. I had to rebel. I didn't get all the attention. It went to you.

Ruth: You can make it now though, can't you? I mean, you're through it. I'm not.

Linda: What have I lost? I lost my mom and dad. I missed the chance to have fun with my parents. I missed everything with my parents. You got it all. I got nothing. (She pounds the table.)

Ruth (soft voice, sounding pathetic): But look where I am now. I was selfish.

Linda (continuing to be enraged): I have to fight my own battles. I don't have to fight your battle. It's your problem. I can't even fix my own self. I'm not going to do it for you.

Terry (quietly): Do you know what it's like to have 5 brothers and sisters? I got everything. And now I want to be dead. All those years I tried to down play everything mom and dad did for me. I know you all hated me for it. And I kept taking.

Monique (with disgust): How can you wallow in self pity when you've gotten everything that we always wanted?

Linda: You feel guilty now, don't you? You took it all and now you're guilty. You're trying to down play it by going to commit suicide but that's to get rid of your guilt. You think that's the solution to the problem.

Terry: It's a lot easier.

Linda: It's a cop out.

Ruth (whines): You know, my side is just as hard as yours. Don't think it's not.

Monique (back to Terry): If you kill yourself, you'll get more attention than ever.

Terry: I don't want that attention.

Linda: That's it! That would be the ultimate bang. Then you've got everyone's eternal attention, blaming it on us, that we made you kill yourself.

While the women were aware this was only an exercise, that they were not talking to their real siblings, they were able to reach feelings that-- for some such as Linda--

they did not know they felt. Others, such as Monique, were surprised at the intensity of their rage. Whether new or not new feelings, after the group exercise some of the women were able to talk about a connection between these feelings and their bulimia. And all of them were able to talk with their siblings about their feelings during the multi-family therapy.

Multi-family Therapy

The two day multi-family therapy is held at the end of the second week of the four week program. This includes each woman's parents and siblings; her husband and children if applicable; and significant others, such as grandparents, aunts, "nannies." Despite the women's hesitation to invite their family members, most family members do attend. The therapy meets for ten hours the first day and for nine hours on the second. The goals of the multi-family are to educate the family about bulimia and the recovery process, to assess family relationships, and to provoke change, i.e., to create situations that will block or alter typical patterns so that something different will happen within the family during the therapy (Wooley and Lewis, 1987).

During the two days, the women address unfinished business with each family member. There often are significant exchanges between siblings; sometimes the issues are not with the siblings, but the siblings are

important in helping the bulimic woman make changes with other family members. Below are excerpts from an exchange that occured in Terry's family.

The therapist started by asking, "What is Terry like?" The parents sit quietly while the siblings respond. They talk openly about her being competitive, interested in sports, ambitious.

Dan: But she doesn't show her competitiveness within the family. She says she wants to be a photographer but...do you have fears about me?

Terry: That I would surpass you. I went to a school with a better photography program. I always thought, "Dan would have loved this; Dad's disappointed in Dan. If Dan had gone to a better school, he would have made it."

Dan tells her that he wants her to learn from his mistakes. She did go to a better school and he encouraged her to send out more resumes than he had.

Terry: But how can I go ahead with this internship, knowing that you had to quit. You're selling real estate now, while I'll be working on this big show. It would feel terrible.

(Later)

Terry to Lorraine: I had to live up to your expectations. You took me under your wing. You were my surrogate mother. What ever I did. I was always thinking, "Lorraine would say don't do this," or "Lorraine would think I should do this." I could never win your approval. It was too hard to live up to. I think I just gave up trying.

(Later)

Lucy: I was bulimic, and then I became--what's it called--agoraphobic; I couldn't go out of the house. But I got over it without going to a therapist.

Mother: We began thinking Terry would have the same problem you did when she lost all that weight. She said that was why she could not leave the house. But

even when she gained the weight back, she still was not able to go out.

Terry to Lucy: I read a letter you wrote; it said how paranoid you felt. How stuck you felt. I never knew it before. I just thought you were bitchy. I don't know if that had anything to do with my problem. I do know I felt bad for you, and wished I had known, or could have helped you.

Therapist: Do you think your becoming equally stuck did help her in some way?

Terry: I don't know. Maybe it made her feel not so alone. Besides, she was real encouraging to me when I was throwing up and scared to go out. She kept telling me I could do it. Maybe it made her feel good to be over her problem and to be able to help me with mine. Maybe it helped her get over hers...I don't know.

(Later)

Terry: I have tried to explain to you all [her siblings] how I feel about mom and dad's drinking, and how I didn't get the kind of love that I needed when I was growing up. I got it in other ways, but not as I needed it. But you always start defending them. You don't understand how I feel. That's why I was apprehensive about this meeting. I think you think I'm crazy for feeling like this. I didn't have the love you older ones had. It [the drinking] didn't happen until you all started moving out and going your separate ways. You moved out and they pulled me in. None of you helped me, or even agreed you saw it happening. I kept feeling more like I needed to be here to take care of them, to see they didn't hurt themselves or each other--especially since none of you would help me! (Crying loudly) I had to do it myself!

These excerpts show the complexity of Terry's concern about her siblings. So many aspects of her life have been affected and still are influenced by Lorraine, Lucy and Dan. While at no point does she say her bulimia is related to any particular event or person, she makes wide sweeps showing multiple connections.

Other examples of sibling interactions during the multi-family therapy can be found in Appendix A. They include excerpts from Hing Sue's family and two families from ITP #3.

Family Seminar

The family seminar meets once each week of the ITP for two hours. It is led by one of the therapists. Theoretical concepts about family systems are presented to the women; they then apply the ideas to their own family. The therapist presents the concepts of family roles. For families to run smoothly, all members throughout the generations have their behavioral roles. These roles may be best understood as stereotypical labeling: the comic, baby, caretaker, egghead, troublemaker, go-between, etc. Most people have many roles and alternate between them at different times. In some families, the roles become rigidified, so that people do not have the flexibility to switch from being the family clown when a particular situation does not need one. Even when the roles are not rigidified, people have a characteristic role that they automatically adopt when under stress.

For some women, being bulimic has become a crystalized role. Others use bulimia to help escape from a role. When a family has functioned for generations with a particular role, someone in the current generation deserting that role can disrupt the family's organization. Therefore, there is likely to be a strong familial pull against the change.

Typically the response is to pull the person back in or if that does not work, to pull someone else in to keep the role filled.

In the seminar on roles, the women are helped to identify their own family roles, predicting who might fill their role if they move out. For the purpose of this study, only those roles that relate to themselves and their siblings are mentioned here. Table 2 lists each woman and the roles she chose for herself and for each sibling. The order of listing may or may not be significant--that was not discussed. While the women chose their own words to represent the roles, there may have been some mutual influence since they were talking together as they were working on their list. By their own initiation some women made two separate listings--a before and an after.

Genograms

During the multi-family therapy each family is taught how to construct a genogram (McGoldrick and Gerson, 1985), which is like a family tree. Multiple generations of marriages, divorces, births, and deaths are recorded. Names, ages, and sex are noted in chronological order.

In addition to the facts, genograms can record emotional connections between family members across the generations as well as transgenerational behavioral patterns. In the multi-family therapy, each family is given crayons to color code a pre-established list of

TABLE 2

Sibling Roles

1. Terry's Family

Terry (age 22)	perfect child best looking mom & dad's favorite most successful most outgoing peacemaker most dependent
Jim (age 29)	happy protective unaware
Lorraine (age 28)	finicky bitchy surrogate mother
Dan (age 26)	lazy content unavailable
Lucy (age 25)	unhappy strange independent
Billy (age 19)	stupid unnoticed unsuccessful

2. Hing Sue's Family

	before bulimia	now
Hing Sue (age 19)	responsible	sick one
	go between	scapegoat
	helpful	selfish
	intelligent	intelligent
	parent pleaser	parent pleaser
Lua (age 16)	sick one baby moody chatterbox	
	(her roles have not changed)	

(continued)

Table 2 Continued

3. Ruth (age 20)		
Ruth (age 20)	showpiece sick princess baby happy one	
Bob (age 23)	stubborn cocky blame taker	
4. Vera's Family		
Vera (age 38)	family roles intelligent go-between goody reliable	marriage roles sick one dependable one connector listener
Hal (age 36)	favorite cute rebellious	
5. Beverly's Family		
Beverly (age 18)	before accident intelligent family hope dad's favorite the giving one one in trouble	after accident complainer sick one the problem
Phil (age 19)	before accident slow one not likely to succeed good boy	after accident perfect one turned out well good boy

(continued)

Table 2 Continued

6. Monique´s Family	
Monique (age 23)	family maintainer available one promising one
Sayra (age 25)	gone always a failure (as adult)
Harry (age 17)	the family´s worry
7. Lois´s Family	
Lois (age 21)	sick one spaced out creative popular fake sensitive considerate guilty
Gail (age 19)	aggressive moody loud mouth
8. Linda´s Family	
Linda was not at this family seminar	

behaviors and traits common to bulimia (Lewis, submitted). The family is to go over the list of traits and circle each person with the colors representing each trait that is applicable. Most people are circled with several colors. The family must agree upon the colors chosen for each person and when necessary, they must find a way to represent their differences of opinions.

When complete, the color coded genogram shows patterns across the generations and between particular members. The genogram is included in this study because of the potential for demonstrating sibling connections. While many of the genograms do not indicate any significant information relevant to the sibships (there were none in ITP #1), there is some color coding that is significant. The genogram in Figure 1 is such an example. This is a genogram from the family of a woman in ITP #3.

> Marla, aged 19, is the youngest of three siblings. Her older sister, Kerry, is identified as "the perfect" child; her older brother, Dan, was always a trouble-maker. Just before Marla's bulimia started, Dan had a serious car accident, in which he suffered minor brain damage. Dan's behavior since then has been erratically "mean," which the family attributes to the effects of the accident. In Group Marla said she felt she had "to make it up to my father...the loss of his only son." She had to be successful for him. Yet, while saying that, Marla remains bulimic which interferes with her becoming successful. A look at the genogram shows that she and Dan have the exact same colors while Kerry has entirely different ones. Marla and Dan share controlling (green), separation (purple), anger (red), alcohol (orange), and some perfectionism (black dotted lines half way around). As will be shown later, their sharing of colors (traits) is a way to represent the message Marla is sending Dan--her need to be equal to or like him.

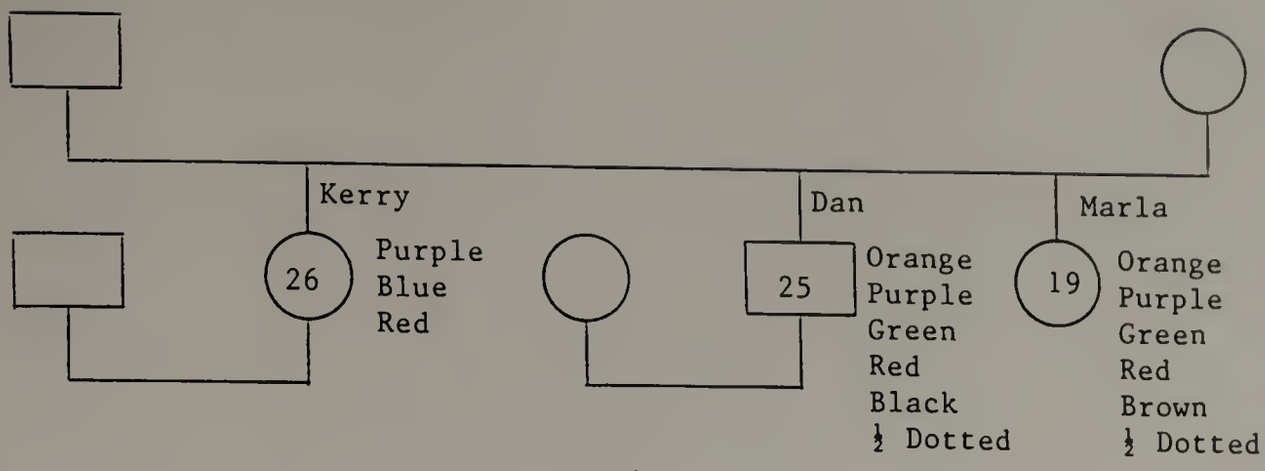

Figure 1: Marla's family Genogram

Note:
All children are purple and all males in 3 generations are purple representing separation.

Color Code

Orange-Alcohol or Drug Addiction
Purple-Separating Issues
Green-Conrolling (Overt or Covert)
Blue-Peace At All Costs
Red-Freely Express Anger
Yellow-Sexual Issues
Black-Health Losses
Brown-Body Image Issues
Dotted Black-Perfectionist

Genograms should not be used to validate sibling connections to the symptom, but they can be helpful assessment tools providing further data. Descriptions of three other color coded genograms from the other ITP groups, can be found in Appendix B.

One Year Follow-ups

The final component used in this study is the one year multi-family therapy follow-up questionnaire. These are mailed to every family member who attended the two day meeting, one year after the woman completes the program. Separate questionnaires are sent to the parents, to the husband, to the siblings, and to the woman herself. For the purpose of this study, only the questionnaires sent to the siblings and to the bulimic woman are considered.

Return rates for the questionnaires are complicated to compute for there is no cut off date for return, and the questionnaires often come in as long as six months after being sent out. Distribution sometimes is dependent on the woman herself, so not all members may get the forms.

Of the four ITP groups of this study, only the first two were over a year ago. Of these sixteen families, forty-four percent returned forms from at least two members. Using this format, there is a 50% return for ITP #1.

There are eleven questions using a Likert scale with space for comments. Five of these questions directly mention a sibling. Two questions inquire if there have

been any changes in the sibling relationship and if so how much are the changes related to the family meeting. Two questions ask if the person is worried about a sibling at this point in time, and if a sibling has developed or had an increase in one of a list of eight problems (such as alcohol dependency, depression, suicide attempts). One question asks for a list of the siblings, identifying who is closest to whom. This last question did not offer any useful information relevant to this study, but the other four questions did. The final question on the questionnaire is an open-ended one asking for comments about the family therapy meeting.

Over 85% of the responses indicated there has been a change in the sibling relationship since the multi-family therapy. About 70% of these responses said the therapy had been important to very important in improving their relationship. The rest said the change either was not related to the therapy or only mildly related. The other significant piece of information from the questionnaire is that all but one of the respondents said they were no longer most worried about the identified patient.

Perhaps the most important information obtained from the questionnaires was the comments. Below are comments from some of the women in ITP #1, and from some of the siblings from ITP #1 and #2. Only three women from ITP #1 had comments that were related to their siblings.

It has increased my closeness to my sister. The family meeting stirred up issues that needed to be dealt with.

[From the brother of the above responder] I try to accept LESS of her "marginal/weak" behavior. I'm more sensitive to her behavior and the causes. [He did not mention the sister of the above quote.]

The questionnaires provide interesting information from the patients and their siblings. The multi-family therapy allowed for some changes in most of the sibling relationships, changes that continued up to at least one year later. Not one person said that the sibling relationship had deteriorated as a result of the therapy. Presumably, for some sibships, there was no change.

The questionnaires had not been designed for this study; therefore, they do not offer direct information about the function of the bulimia and the sibling relationship. However, what is apparent from the responses is that the siblings were aware of each other enough to note changes and, as mentioned above, about 70% noted significant improvement in their relationship.

Message Categories and Analysis

The first half of this chapter described the five study components, using examples from ITP #1. This half reports on the sibling comments: how they were collected, categorized, and interpreted. Through an analysis of all sibling comments transcribed from video tapes of group therapy, multi-family therapy and a family seminar, eight

categories of communication messages were identified. The reliability of categorization was examined through the use of independent raters. The selection process for the categories is described with examples of each category. The findings reported here reflect the data from all four of the ITP groups.

Data Collection

The group therapy, the multi-family therapy, and the family seminar were all videotaped. In total, there were 36 hours of group therapy (no group during multi-family therapy), 19 hours of the multi-family therapy, and 2 hours of the seminar. Of the 57 hours of videotapes, about 10 hours proved inaudible--all from the group therapy.

All but two of the women had siblings. Of the thirty remaining women, all of their comments referring to siblings--during the group therapy, the multi-family therapy and the seminar--were transcribed and then divided into groups of similar communications, i.e., message categories. Some of the comments were one or two sentences; some were extensive conversations with therapists, other patients or siblings.

An early pilot study proved that counting the actual number of sibling comments was impossible. Some comments were one word or one sentence. Others were imbedded in conversations that covered many sentences or were interspersed with other topics. Therefore, it was decided

that all comments would be collected and categorized according to similar meanings. The only counting would be of the number of different meanings, not the number of actual comments. Seven message categories were identified: equalizing, dirty fighting, connecting, flagging, deflecting, separating, peacemaking. (How the categories were selected and their definitions are included in the next sections.)

Regardless the frequency of a message from a bulimic woman to any of her siblings, it was given a count of one. That is, a woman may have nine comments to one brother and two sisters that fit the description of the dirty fighting message. The dirty fighting category would only receive a score of one. If the same woman also made two comments that fit the equalizing category about these same three siblings or any others, then equalizing would also receive a score of one. She would then have two messages credited to her.

Of the thirty-two women, two had no siblings and no messages were found for one woman. The other twenty-nine women had either one, two, or three different messages to one or more of their siblings. In all, there were 49 different messages. Since some of the comments were towards "siblings" or "my brothers," no effort was made to track the messages to a particular sibling. However, Table 3 shows the breakdown of the number of statements that each woman made for each message category. For

TABLE 3

Number of Times Each Message Appeared

Woman	Message	1-3	4-10	>10
1 (Terry)	connecting			x
	equalizing			x
	dirty fighting		x	
2 (Hing Sue)	deflecting	x		
3 (Ruth)	connecting			x
4 (Vera)	deflecting	x		
5 (Beverly)	dirty fighting		x	
6 (Monique)	connecting		x	
	equalizing		x	
7 (Lois)	dirty fighting			x
8 (Linda)	dirty fighting			x
9	flagging		x	
	connecting	x		
10	dirty fighting			x
11	equalizing			x
	dirty fighting			x
12	equalizing			x
	dirty fighting			x
13	connecting	x		
	separating	x		
14	dirty fighting	x		
15 (Michelle)	dirty fighting			x
	flagging		x	
16 (Jeanne)	deflecting	x		
	dirty fighting	x		
17 (Irene)	peacemaking	x		
	connecting	x		
	equalizing	x		

(continued)

Table 3 Continued

Woman	Message	1-3	4-10	>10
18 (Clair)	equalizing		x	
	flagging	x		
19 (Denise)	equalizing	x		
20	no siblings			
21	no messages			
22	connecting		x	
23 (Maria)	separating			x
24	equalizing			x
25 (Laurie)	equalizing			x
	connecting			x
26 (Connie)	deflecting	x		
	dirty fighting	x		
	flagging	x		
27	equalizing	x		
	separating	x		
28 (Darlene)	deflecting	x		
	peacemaking			x
	equalizing			x
29	no siblings			
30 (Marsha)	flagging	x		
	other		x	
31 (Nora)	dirty fighting			x
32	equalizing			x
	flagging	x		

example, by looking at Table 3, it is clear that Monique made between 4 and 10 statements that fell into the connecting category while Ruth made more than 10. For all the reasons mentioned above, actual numbers were impossible. Further, it must be noted that these are only relative numbers since those woman who were more vocal would have higher numbers because they talked more, not necessarily because they have more sibling issues.

Table 4 shows the types of messages identified for each of the thirty-two women and the number of times each message was used. The numbers under the column marked women refer to the numbering of the women in each ITP group. That is, numbers 1 through 8 are in ITP #1; numbers 9 through 16 are in ITP #2, etc. Names of women identified in the examples are noted beside the number. This makes it possible to see that Terry, described earlier in this chapter, has three messages to one or more of her siblings, while Beverly has one.

Selection of Categories

In choosing the categories, some were self-evident because the comments included an appropriate label. For example, many comments included the word "equal," or "the same," suggesting an equalizing category. An example of one of these comments is, "My brother was always the bad child and I was the good one. Now that I have this problem, I am more like him. I think he likes me better now that we're more equal." The categories that most often

TABLE 4

Numbers and Types of Messages

Woman	# Messages	Messages
1 (Terry)	3	connecting equalizing dirty fighting
2 (Hing Sue)	1	deflecting
3 (Ruth)	1	connecting
4 (Vera)	1	deflecting
5 (Beverly)	1	dirty fighting
6 (Monique)	2	connecting equalizing
7 (Lois)	1	dirty fighting
8 (Linda)	1	dirty fighting
9	2	flagging connecting
10	1	dirty fighting
11	2	equalizing dirty fighting
12	2	equalizing dirty fighting
13	2	connecting separating
14	1	dirty fighting
15 (Michelle)	2	dirty fighting flagging
16 (Jeanne)	2	deflecting dirty fighting
17 (Irene)	3	peacemaking connecting equalizing

(continued)

TABLE 4 Continued

Woman	# Messages	Messages
18 (Clair)	2	equalizing flagging
19 (Denise)	1	equalizing
20	No sibs	
21	0	
22	1	connecting
23 (Maria)	1	separaating
24	1	equalizing
25 (Laurie)	2	equalizing connecting
26 (Connie)	3	deflecting dirty fighting flagging
27	2	equalizing separating
28 (Darlene)	3	deflecting peacemaking equalizing
29	No Sibs	
30 (Marsha)	2	flagging other
31 (Nora)	1	dirty fighting
32	2	equalizing flagging

were self-identified are connecting, equalizing, and peace-making.

For the rest of the statements, the intent of the message was assessed. For example, a dirty fighting category was chosen for this statement, "I´m afraid to give up my bulimia: I might gain weight and then I would be fatter than my sister. This is the only thing I could ever do better than she. This is the only thing I could ever beat her at." This suggests that weight was being used as a covert means of fighting; competition is not openly allowed. Statements that fell into categories that were identified by clinical assessment of intent fell into categories called dirty fighting and deflecting.

Strikingly, most of the statements fell easily within these five categories. Those statements that did not were re-read, looking for possible patterns. This led to the creation of the last two categories--flagging and separation. The types of statements that ended up being identified as flagging include, "Mom and dad are really drinking themselves into the grave. [My brother and sisters] refuse to see this. I don´t know what this has to do with my bulimia, but I sure hope it can help somehow." Flagging was chosen since the statement seemed to suggest that bulimia was a way to call attention to a family or sibling problem.

An example of a statement that fits the separation category is "Mom calls me constantly to come over and help her with [my younger brothers.] I want to have my own life, but I hate to tell her no. Sometimes I am too tired from bingeing and vomiting to be able to go home and help her." The separating label was chosen since the bulimia provided the woman an excuse to stay separate from the family. All but one of the statements fit within these seven categories. That one was relegated to a category called Other.

The Categories

The eight categories are listed below with their definitions. The number beside the category represents the number of times this message was used (for different siblings) according to the researcher's sorting. The categories are listed and described in the decreasing order of frequency they were used for sending that particular message to one or more siblings. Each is followed by an example.

equalizing (12)

An equalizing function is indicated when a comment suggests bulimia is a way to help the woman feel like she is not so very different from her siblings. Comments reflect her feeling different from her siblings by her having been the "good" child, having more natural abilities or more socially acceptable attributes, having had less problems, having achieved more or been more successful in life.

Example: I felt so bad that my sister never dated in high school. she was very fat and never went out. I was very popular and had lots of friends. I was a cheerleader and on the swim team. She never did anything but stay home and study.

dirty fighting (12)
A dirty fighting function is indicated when a comment suggests the bulimic woman does not acknowledge anger at or competition with her sibling. This is particularly true for a woman from a family that discourages overt expression of these feelings. Adhering to family rules but still feeling the anger, the woman carries on a silent battle. This may be a contest around thinness, or it may be an attempt to outshine a sibling and get more attention from parents.

Example: My brother was sickly as a child. We always had to be kind to him, do things for him. He got all the special attention. I was not allowed to express any anger at him....I am sure he must be annoyed at all the times I call him in the middle of the night complaining about my binging and purgeing.

connecting (8)
A connecting function is indicated when a comment suggests bulimia is a way to connect with or relate to a sibling. This may occur when siblings used to be close and now are emotionally or physically out of touch, or when the siblings have never been close and the woman wants to establish a contact. It may also occur when the siblings have nothing else in common, e.g., food and dieting become their main form of connection.

Example: My sister and I used to hang around all the time when we were teenagers. Once we went to college we grew apart, and now we lead entirely different lives. We hardly ever see each other. Well, that is before I told her about my laxative abuse. She is so worried. She writes and calls me with any new article or book she can find on bulimia.

flagging (6)
A flagging function is indicated when a comment suggests the bulimia attracts attention to the woman, a sibling, or the family. The woman may be concerned about herself and wants family assistance, but cannot ask for it directly. She may be calling attention to the parents' marriage or to an unacknowledged family problem. The message may be to get the siblings' attention, essentially saying that things are not right with the family and they need to deal with it.

Example: I did not understand it at the time, but my bulimia was an attempt to alert my family that I was headed for a nervous breakdown. I was taking on too much responsibility, doing everything for everyone. I

couldn't say no and I couldn't get angry. I looked fine, so no one saw how desperately I needed help.

deflecting (5)
A deflecting function is indicated when a comment suggests the bulimic woman hopes her symptom will protect another sibling from parental concern or disapproval, or that her symptom is of a more manageable size for parents to handle than the problems of another sibling.

Example: It's easier for my parents to handle my eating problem. They know what to do about it; I started therapy the week after I told them. If they find out my sister is having an affair with a married man, after my father ran off with another woman, I don't know what they would do. My mother might really flip out.

separating (3)
A separating function is indicated when a comment suggests the bulimia provides the woman with a means to distance herself--emotionally, or physically--from her family. This may occur when the woman has been the caretaker, or comes from an extremely enmeshed family but now wants out. It may also occur when the woman no longer wants to change her role in the family. Bulimia allows her to stay distanced from everyone's expectations, the family's and her own.

Example: It's been a standing joke that if my sister got an A in Math, I got one in English. If she got a promotion, I got one. If she excelled in piano, I needed to excell in something. It got too hard to keep up, but I could not tell anyone for I felt like such a failure. The bulimia was debilitating; it was one way out, but I felt like a total failure.

peacemaking (2)
A peacemaking function is indicated when a comment suggests the bulimia will bring an estranged sibling back into the family's good graces, or will provide a reason for quarreling siblings or a sibling and parent to make-up.

Example: I hate it when everyone fights. I sometimes wish my brother would just move out. The only time they are not all screaming at each other is when my potassium level drops so low I faint and have to be hospitalized.

other (1)

There was one message that did not fit into any of the above categories. A summary of all of the woman's statements sends this message: "Please note siblings, I am quite upset because I'm not as good as you all; you have all the things that are valued, and I feel like a nothing."

It should be noted that the above examples are from women who were able to identify the function of the bulimia in their communication to a sibling. Most statements are not so concise. These examples were used precisely because they were brief and it was easy to see the message. Clinical examples giving more detail for each category can be found in Appendix D.

Reliability Check

Since the selection of categories was based on only the researcher's interpretation of the statements, it was important to check for reliability of the categorizations. Fourteen statements--two from each of the seven categories according to the researcher's selection--were given to a group of 26 professional therapists together with definitions of the eight categories. (See Appendix D for the definitions and the statements.) The selection of statements was based on length; statements needed to be brief enough to be quickly read. The 26 sorters were divided into groups of three or four. There were 7 groups in all. They were instructed to find which category, if any, best fit each statement. They were told they could add other categories that may fit better. They were not told how many fit each category according to the

researcher's findings. To avoid complications, only statements with one message (as assigned by the researcher) were included in the reliability check.

The results of the original sorting of the researcher as compared with the reliability check of the seven groups shows a strong consistency in the categories of messages chosen. There was 100% agreement for the connecting and equalizing categories. There was an 87.5% agreement for peacemaking and dirty fighting categories. There was a 75% agreement for the flagging and the separating categories. One of the two deflecting statements received a 100% agreement, but for the other statement, there was considerable disagreement. Only two of the groups of raters placed the statement in the same category. On rereading the statement, it appeared the message was so vague that those unaware of the woman and her treatment issues would not be able to assess the meaning of the statement. The sorters found all of the statements fit one of the seven categories. No statement was assigned to the "other" category.

Analysis of Messages

Using the researcher's sortings, the 49 messages fell into the eight previously described categories. There were 13 single messages, 12 double messages and 3 triples (see Table 4). With two exceptions, equalizing was always paired with one or two other messages. All but one of the double and triple messages included either equalizing or dirty

fighting. Equalizing-connecting messages were the most frequent double message combination (4).

There is no clear significance to the meaning of the order of frequency. What is clear is that equalizing and dirty fighting are the more prominent communications--whether alone or with another message, and that they have dichotomous implications. Both represent clear affective expressions: equalizing is caring and dirty fighting is angry. By implication, it is possible to assume that their more frequent use as communication messages may reflect the two polar affects that may be difficult to express directly--caring and anger. However, there may also be other possible implications of their frequency.

Summary

This chapter has described and summarized the findings of the function of bulimia in sibling relationships. The first half described the eight women in ITP #1, listing their siblings and giving relevant history. The five components of the study were then described--group therapy, multi-family therapy, family seminar, genograms, and one year multi-family therapy follow-up questionnaires. Each component was accompanied by examples from the women in ITP #1.

The second half of the chapter reported on the findings. There were forty-nine messages that fell into

The second half of the chapter reported on the findings. There were forty-nine messages that fell into eight categories. In decreasing order of frequency they are equalizing, dirty fighting, connecting, flagging, deflecting, separating, and peacemaking. The first two were most frequently used together with one or two other categories for multiple messages.

The categories were checked for reliability by an impartial group of raters. There was significant reliability in all but one of the two statements in the deflecting category. The discrepancy may have been due to the vagueness of the statement. This chapter has reported on the actual findings; the significance of this data is covered in the next chapter.

C H A P T E R V

DISCUSSION

The last chapter described the women in the study and categorized their comments about their siblings into seven types of messages. This chapter will look at the major themes expressed by those messages. First several key issues in bulimia and in the sibling relationships are reviewed. This is followed by a discussion of the meaning of the interface between bulimia and the sibling relationship are presented. Three major themes have been identified.

Review of Bulimia and the Sibling Relationship

There are many factors that go into understanding bulimia. It is a complex symptom that defies easy explanation. The literature, as described in detail in Chapter One, is replete with meanings from physiological, psychological, cultural, and family factors. Each are briefly summarized here. Physiologically, not eating enough food can lead to the body's self-preservation through increased eating, i.e., bingeing (Garner and Garfunkel, 1984). Psychodynamic psychotherapy has many explanations for bulimia based on the intrapsychic world of the bulimic woman (Boskind-White and White, 1983). The

cultural changes in a woman´s role--transfering her modeling to her father--support her independence and career without concomitant access to power or expression of anger (Root et al., 1986; Wooley and Lewis, 1986). Also seen as a cultural factor is the significant increase in reporting if not actual occurrence of sexual abuse (Root et al., 1986; Wooley and Kearney-Cooke, 1986). Family therapy has attempted to explain bulimia through attention to nuclear family coalitions and style of conflict resolution (Madanes, 1984; Schwartz et al., 1984). The extended family legacies are also important in understanding bulimia (Roberto, 1986a, 1986b). Family therapists, however, when talking about families are referring primarily to the mother-father-identified patient triangle. They are not speaking about the separate sibling subsystem.

Bulimia, then, is a complex symptom. When narrowing the focus to just the sibling relationships, a gap in the literature becomes obvious. Family therapists have looked at both bulimia and at siblings, but not at their interface. Schwartz et al. (1984) see bulimia "not as a dreaded enemy, but...as a signal that something needs to be taken care of..." (p. 290). That "something" has not been uniformly agreed upon by therapists. This study attempts to identify a previously unexplored part of that "something" by looking at the potential importance of brothers and sisters in the onset and maintenance of bulimia. It was hypothesized and the findings do support

that the symptom of bulimia may carry an inherent fraternal message.

Siblings can be important in each other´s lives. Siblings are "the first social laboratory" (Minuchin, 1974, p. 59) for exploring interactional skills. They have their own boundaries, rules, and norms. For children, the sibling subsystem has its own unique quality, separate from parents and from the family as a whole. Siblings can be vital in making the transition from family to the peer world: in learning how to fight, love, and negotiate--skills that have life long importance. Relationships between siblings, while also influenced by the parents, exist apart from parental intrusions. Communication between siblings, apart from parents, is also important.

Three Themes

In analyzing the communication messages, three themes about the meaning of bulimia in sibling relationships stand out. Bulimia is a means for indirectly expressing affect to a sibling, whether the affect is positive or negative; for getting out of a complementary role with a sibling; and for representing the intense ambivalence that constricts the relationship with a sibling. Each of these themes is described below, and the mesasges that fall into each theme are listed. Table 5 on page 115, summarizes the seven messages across each of the themes.

Expressing Affect Indirectly

All seven messages are an indirect expression of some affect--an expression of caring, anger, or need for emotional distance. The caring messages include equalizing, connecting, flagging, deflecting, and peacemaking. The angry one is dirty fighting, and the need for distance is separating. They are all indirect in that they send a covert message rather than a straightforward one. The messages express a concern the woman has about a sibling. The two most frequently used messages identified in the study--equalizing and dirty fighting--include both caring and anger. This dichotomy of affect is not surprising, since there is often an overlap between these two emotions. What is curious is that both need to be expressed indirectly through the symptom--the anger as well as the caring.

The separating message seems outside of the caring-anger dichotomy, but represents an indirect expression of the need for more distance between the bulimic woman and her siblings and/or parents. For some reason she is unable to openly express her need for more emotional distance from her family.

In an attempt to better understand why a bulimic woman uses an indirect means of expressing her caring, her anger towards a sibling, and her need for emotional distance a futher explanation is described below.

Caretaking

Bulimic women have been described as peacemakers and go-betweens (Garner and Garfinkel, 1984), women who are acutely sensitive to and physiologically responsive to the feelings of others (Minuchin et al., 1978). They come from families that want peace at all costs (Root et al., 1986). With these familial and personal characteristics, it is not surprising that women who are bulimic are highly tuned in to the feelings of significant others. Recently researchers have been learning that siblings now need to be considered among the significant others (Bank and Kahn, 1982; Dunn and Kendrick, 1982; Minuchin et al., 1967). Siblings are not just by-standers to the drama between the identified patient and parents.

As described in Chapter Four, equalizing is a way for a bulimic woman to tell a sibling she wants to rebalance the differences between them. This most often occurs when she has been blessed with more socially valued natural attributes than her siblings and has been the recipient of the "inherited" positive family roles. She may feel discomfort with the inequality between her gifts and her siblings'. Since two children can not occupy the same role simultaneously (Bank & Kahn, 1982; Boszormenyi-Nagy & Spark, 1973), family myths--sometimes passed down through the generations--encourage the development of complementary roles, e.g., diametrically opposite ones. If one child has been designated as the optimistic one, the

other usually has been deemed the pessimistic one; if one is labeled successful, another is seen as the unsuccessful one. If the bulimic woman had been the good child or the favorite child, she may use bulima as an opportunity to rebalance the roles. When she becomes the sick one, she gives up her special role, thereby leaving that role open for another sibling.

Terry, from ITP #1, tells her family about her discomfort with the inequality between Dan and her, relating to photography and between Lucy and her around socializing. She verbalized her connecting intent of bulimia when she said, If I am successful, I will leave them all behind." Her love and caring for her family led her to the only solution she could find--lowering her own ability in order to stay connected. She did not believe that telling them of her concerns would have changed the inequality or her isolation, but developing bulimia did.

Flagging as a caretaking maneuver, starts out by calling the siblings together to essentially announce that there is a problem that needs some attention. It can take many forms. Jeanne, from ITP #2, used her bulimia to solicit her siblings' help for dealing with their parents' marital battles. The family pattern established that each oldest child living at home had the responsibility for the caretaking of the parents. Jeanne was now the last child there. Consciously, Jeanne said she did not want to bother her siblings by asking for help because they were

establishing their lives and careers in another state. On an unconscious level though, her bulimia did just that. Her brother and sister responded to Jeanne's flagging by talking to her about the hopelessness of trying to change the parents and by supporting her separation from the parents.

The last two caretaking messages are deflecting and peacemaking. Deflecting is a way for the bulimic woman to take care of a sibling who needs emotional space from parents and to protect parents from having to deal with a sibling's overwhelming problems. Peacemaking is a way to rally the family together, to smooth over individual past hurts and to bring estranged siblings back into the fold.

Unlike Jeanne, Darlene, from ITP #4, was aware that her bulimia was a double attempt to heal the wounds between her parents and Phyllis and to deflect parents' attention so Phyllis could get the distance she needed to get well.

In each of the above examples of the indirectly expressed caring messages, the bulimic woman uses her symptom in a covert effort to help a sibling. The need for the indirectness is not clear but one possible explanation is that actions speak louder than words, and when other factors are present that lead to bulimia, the action of bulimia becomes the best help the woman can offer. Since her concerns are unconscious or she only vaguely understands them, the means she takes to help her family must remain disguised.

Anger

The early family system understanding of psychosomatic families (Minuchin et al., 1978) identified four characteristics: enmeshment, overprotectiveness, rigid boundaries, and lack of conflict resolution. These families do not deal openly with conflict; they attempt to deny disagreements and to smooth over or ignore tensions. To these families appearance is important (Schwartz et al., 1984), not only their physical presentation, but also their emotional facade. Enmeshed families tend to pull together against outside intrusion. The side effect of this united front--without acknowledgement of the internal differences--is that the differences and the anger go underground. They only get aired through indirect expression, i.e., dirty fighting.

Another factor in the indirect fighting may be a woman's loyalty to her extended family (Boszormenyi-Nagy and Spark, 1973). If a woman is raised in a family that only expresses anger indirectly, then she will find her own way to express her anger while maintaining her loyalty to the family. One way for many women is through the symptom of bulimia.

In families where children did not learn to directly express their anger, competition, jealousy, or other strong emotions, they had to learn indirect, or "dirty" ways to express those feelings. When those feelings are carried

over from childhood, they gain momentum from the length of time they have been muted. Bulimia is a safe way to explode (into a toilet) about the old grievances towards a sibling.

Beverly, from ITP #1, was raised in what Root et al. (1986) called the "Perfect Family." They presented a good appearance to the outside world. The physical as well as emotional scar Beverly carried from her brother's kick had never been discussed within the family. As she began to talk for the first time about her intense resentment towards him, she wondered if her rage after the accident when her friends died had put her in touch with her blocked rage at Phil. Bulimia had become a safe way to hold on to the anger yet still maintain the family's focus on appearance.

In essence, the most common reason for the dirty fighting message of bulimia is unfinished business. The mean or betrayal images of a brother or sister, frozen from childhood (Bank and Kahn, 1982), may feel raw and current, a situation ripe for revenge.

Need for Emotional Distance

By some classifications, bulimic families are described as enmeshed (Minuchin et al., 1978; Root et al., 1986; Schwartz et al., 1984). In enmeshed famlies the emphasis is on the family as a unit, not on individual needs. Overprotection exists between all members; personal boundaries between individual members are discouraged;

individuation is discouraged. The needs of the family come before individual needs.

Separating and leaving home are steps usually seen as important in the development of a young adult (Haley, 1976). Whether the separation is physically moving out of parents' home or only emotionally developing a life separate from the rest of the family, healthy development is dependent upon young adults learning how to establish lives/identities apart from the family of origin. This is not to suggest that total contact with the family should be cut off, but the young adult needs to have the ability to function separate from the family.

However, this basic need for a person's movement to the next individual life stage (Erikson, 1950), conflicts with the unwritten rules in enmeshed families. Bulimia then becomes an acceptable way to gain some separateness while still adhering to the family rules. Even if not living under the same roof as parents or siblings, the bulimic woman keeps in contact--writing, visiting, and telephoning frequently. She continues to be embroiled in family conflicts; parents ask her to intervene with siblings; siblings engage her in their battles or worries about parents. Her emotional energies are closely tied up with her parents and her siblings. However, when she is bulimic, she has a serious problem that isolates her from her family. She is excused for not coming over more often

if she is home throwing up all day. Parents and siblings do not rely upon her to join in Sunday meals, Saturday shopping, and other regular family events. They may be angry at her being bulimic, but it at least gives her an excuse as to why she needs to keep her physical or emotional distance from them.

Getting out of a Complementary Role

Getting out of a complementary role with a sibling is the second of the themes found in the seven messages. Complementarity of sibling roles as used here means a mutual participation in an unequal relationship, with one sibling in a one-up position and the other in a one-down position. The power of the complementarity comes from the historical bases of the pre-established family roles evolved throughout prior family generations (Boszormenyi-Nagy & Spark, 1973). A bulimic woman is often in the caretakering role within her family of origin; she is often the "kind" or "good" child. Although she may have angry feelings, she is fearful of expressing them because 1) she is good, and good people do not hurt others' feelings, 2) she is nice and people may not like her if she does something that can be preceived as unnice, 3) she is the caretaker and if she reneges on her role, more responsibility may be placed on her siblings. Yet she knows that if she does not express herself more directly--take on a different role--she is hurting herself. She is caught between pleasing others (caretaking), and taking

care of herself (direct expression of anger and more separation). Bulimia helps her maintain her old role while numbing her wish for change. It also preoccupies and debilitates her so that it looks like she is incapable of being more independent (separate).

Any change in her behavior will inevitably affect her siblings, either directly or indirectly. If she becomes more open with her feelings, she may begin telling a brother she does not want to babysit for his six children every week. She may have to leave behind a sibling who is not so expressive, her change underscoring the differences between them. She may become more assertive and hence successful in her career, which may cause her to outshine a brother or sister. Any major change she makes will provoke a change in her relationship with her siblings and in the manner in which they see and treat each other. At least five of the communication messages effect a complementary role change: equalizing, dirty fighting, connecting, deflecting, and separating. She runs the risk of disrupting the long standing complementary roles if she attends to her own needs which may make her more successful than or unequal to her siblings; if she puts aside her efforts to connect with or protect (deflect) a sibling; if she moves to a more direct expression of anger; or if she gives herself the emotional distance necessary for her continued development as an independent woman.

Terry writes, "I think we kids all voice our opinion better. We're certainly a tighter knit family unit now.

Monique writes, "[Since the ITP] I have been internalizing the concept of my separateness from my sister. This has allowed my relationship to become stronger....I feel I am not tied up protecting [my brother and sister]. I have discovered how to be with them without my feeling responsible for their pain, and therefore, have more to give as a stronger person."

Lois returns the follow-up forms for herself, her mother and her father. She sends Gail's empty form back with a note saying, "Gail can not fill hers out since she is out of state." In her own form, she leaves blank the sections that specifically ask about her siblings. However, in the grid showing family closeness she writes Gail's name next to her own.

There were a variety of sibling responses. Not all are reproduced here, only some that represent the more common themes. It is apparent that for some siblings, changes occured not only between them and the bulimc woman but also among the other siblings as well.

Better understanding of the bulimic behavior. How we all contribute to her bulimia. Also, a lot of feelings towards my brother I didn't realize I felt...I don't think I give more support to my sister now, but it's a different kind of support....I'm more assertive in expressing my anger at my brother.

[From the brother mentioned above] Amount of communication was good. Was initially between family members, some of what was never discussed before. I now talk with her on a regular basis. I learned I am vulnerable to deception. I used to take things at face value... and my inability to accept the signs and symptoms of bulimia. [He did not mention the sister from the prior quote.]

My sister and I are the least competitive we've ever been and the most up-front. It helped my sister, but it also helped me put my family relationships in better perspective. I no longer feel I have to caretake my mother and my brother.

Immobilizing Ambivalence in the Sibling Relationship

The third theme is the intense ambivalence between siblings, a dichotomous love/hate relationship. It is as if the woman can not decide which she feels more for she does feel each emotion intensely. The bulimia may help her numb one of the conflicting feelings but still does not free her to act on the other one. Their current relationship is hindered because they have not been able to put their past issues to rest. While there may be pain from their past, there must have been something caring too, because they do not want to let go of each other.

Neither rational talking nor emotional venting about their early experiences together frees them from the grips of their past. It is if the images from childhood are frozen in their memory, unyielding to any new perceptions (Bank & Kahn, 1982). It seems if they were to melt the former recollections, they would somehow lose their past. While there is pain in holding on, letting go may represent something even worse--perhaps death or nothingness.

For some women, the hatred that can not be forgotten may represent the most emotional recollections from their childhood. They may have grown up in a household where expression of all strong affect was forbidden or where one or both parents were depressed. The anger among the siblings may have been the one emotion that kept them feeling alive. If they fought, they knew they felt

something, and if they felt something then they knew they were alive (Lewis, 1986b; Minuchin et al., 1967).

For other children, the intensity from their childhood may represent the only bonding they had with a consistent other. When parenting is inconsistent or inadequate, children often turn to each other. As long as there is a mutual nurturing, each of the children can receive some of the bonding necessary for development of identity and self esteem. When one child begins to look outside the sibship for support and nurturance, the other children may feel traumatized by the abandonment (Kahn, in press). The emotional wound is deep, the rage violent. As the children move to adolescence and adulthood the origin of the rage may be long forgotten. What they have left is the mixture of fierce hatred and intense affection. This taking in affection from each other but also rejecting it, metaphorically represents the bulimic behavior of bingeing and purging.

The most likely messages that fall within this theme are dirty fighting and separating. The continual conflict between the love and hate often gets played out through dirty fighting, that is, the love is expressed openly while the hate is not. Sometimes, though, both feelings are openly expressed. Either way, the intensity of their ambivalence about each other makes separation more difficult. Bulimia, then, provides a temporary escape from the constricting web of this intense relationship.

TABLE 5

Seven Messages Across the Three Themes

	Eq	DF	Con	Flag	Def	Pc	Sep
Indirect Expression	x	x	x	x	x	x	x
Complementary	x	x	x	x			x
Ambivalence		x					x

Abbreviations

Eq = equalizing
DF = dirty fighting
Con = connecting
Flag = flagging
Def = deflecting
Pc = peacemaking
Sep = separating

This immobilizing ambivalence was seen most clearly with Lois, in ITP #1. Father's depression and mother's inconsistent emotional availability during Lois' childhood drew her closer to her older sister, Gail. During the ITP, Lois' most emotional responses were always related to her sister. Yet most of her comments about Gail included her love and her hatred. "Gail is the most important person to me--more than mommy and dad. I think if I were to die, it would be harder for Gail. But I hate her." Throughout the program, Lois made little progress in understanding this paradox. Both she and Gail blocked all efforts to talk with each other. According to the one year follow-up questionnarie, Lois' bulimia had decreased, appearing only when she was with Gail. She did not forwarded the sibling questionnaire to Gail. These two facts together suggest the sisters had not been able to move beyond their stalemate. Therefore, it seems likely that their unresolved ambivalence towards each other immobilized Lois, keeping her caught in the relationship with Gail--unable to pull closer yet unable to pull away.

Summary

This chapter has offered a brief review of the multi-dimensional understanding of bulimia--the physiological, psychological, familial, and cultural influences. Three

themes were posed for understanding the meaning of bulimia in the sibling relationship: expressing affect indirectly, which includes caretaking, anger, and need for emotional distance; getting out of a complementary role; and immobilizing ambivalence in a sibling relationship. Each is exemplified by information from the women in the ITP.

C H A P T E R V I

SUMMARY AND IMPLICATIONS

Summary

This study has looked at the role of bulimia in a woman's relationship with one or more of her siblings. Thirty-two women participating in an Intensive Treatment Program (ITP) for Bulimia at the University of Cincinnati Medical Center were the subjects of this descriptive study. This is a four week treatment program where the women live in hotel apartments with their own kitchens, and come to the clinic each week day for 8 hours of treatment. While one group was described in detail, the study included four ITP groups of eight women each. All of the women's comments about their sibling relationships were tracked through five components of the program: a daily group therapy (totaling 18 two hour sessions), a two day multi-family therapy (totaling 19 hours), a two hour family seminar, genograms, and one year follow-up questionnaires.

All of the women's comments related to their siblings were transcribed from the video recordings of the therapies and the seminar. Each of the sibling comments was sorted into similar categories of common messages. Of the thirty-two women, two had no siblings and no messages were found for one woman. The remaining twenty-nine women had either

one, two, or three different messages to one or more of their siblings. In all, there were forty-nine different messages, falling into seven categories. In decreasing order of frequency the categories are equalizing (12), dirty fighting (12), connecting (8), flagging (6), deflecting (5), separating (3), peacemaking (2), and other (1).

In order to check for the reliability of the selection of categories, 26 independent raters--divided into seven groups--were given fourteen sample statments, with the list of the message categories and definitions. They were told they could add other categories that might fit better. There was high consistency: connecting and equalizing had 100% agreement; peacemaking and dirty fighting, 87.5% agreement; flagging and separating 75% agreement. One deflecting statement received 100% agreement while the other had minimal agreement.

In considering the seven messages, three themes stand out for understanding the use of bulimia in the sibling relationship. Bulimia allows for an indirect expression of affect to a sibling; it serves as a means of getting out of a complementary role with a sibling; and it represents immobilizing ambivalence in the sibling relationship. All seven messages fall into the indirect expression of affect theme since each message is a way to covertly send a communication to a sibling. Five of the seven are indirect caring messages: equalizing, connecting,

flagging, deflecting, and peacemaking. The dirty fighting message indirectly represents angry feelings. The need for emotional distance is expressed through the separating message.

The second theme is altering or getting out of a complementary role with a sibling, As the woman understands the underlying meanings of her bulimic behavior, she usually changes her role in the family. A change in one person's role effects everyone else's. Hence, her progress may inevitably provoke changes in her relationship with her siblings and in the roles they have established within the family. Bulimia numbs the woman's wish for and her ability to make the changes, which protects her siblings from the ramifications of her changes. Five communication messages represent the complementarity of roles between the bulimic woman and one or more of her siblings: equalizing, dirty fighting, connecting, deflecting, and separating.

In the third theme, bulimia allows a woman to remain immobilized by her ambivalence towards a sibling. Old sibling issues, old behavioral and interactional patterns are never resolved. This is homeostatically balanced by the warmth and caring from their earlier relationship. The frozen images from their childhood leave the woman immovable between the two dichotomous feelings. Bulimia helps the woman remain caught, unable to resolve the past

issues and unable to reestablish a more current relationship. At least two of the messages represent the immobilizing ambivalence between siblings: dirty fighting and separating.

All three of these themes offer one possible explanation for the role of bulimia relevant to the siblings--it prevents the woman from dealing with conflictual or uncomfortable feelings and from moving on in her own life.

Implications

While this study opens the door to the question of the importance of the sibling relationship in bulimia, it is a descriptive study and hence, incurs some obvious limitations. Primarily, the sample was small, consisting of only 32 women. These women participated in only one type of treatment program. The fact this was a residential program, that the women were living in a family-like environment, may well have brought sibling issues more to the forefront. No comparison was made with women in other types of bulimia programs. This study did not compare messages sent through bulimia to siblings versus messages sent to other family or non-family members. It did not compare messages sent through the symptom of bulima with other symptoms. Data gathering had some evident

limitations, being based soley on the women's own comments about their siblings.

One theme noted was the indirectness of expressing affect. While this may be relevant to bulimic women, it may also be a family style. And while the sibling subsystem may be important to the symptom, brothers and sisters are also a part of the whole family system. There are bound to be influences across the two subgroups.

It is worth repeating that this study does not intend to imply a causal relationship between bulimia and siblings. While there may be for some women, for many others the sibling influence is only one part of the complex symptom of bulimia. Given the above limitations, the findings do show that at least for twenty-nine of the women in this study who had siblings, bulimia functioned as some form of a communicating message to their siblings.

Research Implications

Even with these limitations, this study does provide some ideas that merit further research, and it does offer implications for clinical practice. This is a start into a relatively unexplored area where much more needs to be understood. The messages, as defined here, are all indirect forms of communication. An obvious question is why the need for the indirectness, especially for the caretaking messages? Avoiding direct confrontation (i.e., dirty fighting) is at least understandable in families that avoid conflict. However, if a woman is concerned

about the inequality between her ability or status and her siblings', why must she express her concern non-verbally through bulimia? Further, why is one particular message chosen over another and are there different types of messages to brothers than to sisters? For instance, several women in the study used bulimia to flag help for a sibling while others used it to deflect attention away from a sibling.

These questions lead to several implications for further research. One possibility is a systematic look at the types of messages a woman uses and the type of family she comes from. Root et al.'s (1986) classification of the Perfect Family, the Overprotective Family, and the Chaotic Family could be used as a basis for such research. For example, do women from Perfect Families send more dirty fighting messages than peacemaking ones?

Minuchin et al.'s (1978) four characteristics of the psychosomatic family (enmeshment, overprotection, rigidity, and lack of conflict resolution) could be correlated with the types of communication messages a woman sends through the symptom of bulimia.

Another topic for future study is at what point does the sibling connection with bulimia begin? Some women mentioned their bulimia started as a direct result of something having to do with a sibling. ("It started right after my brother left for college.") Some women were

already bulimic when they recognized a secondary gain in their bulimia--an opportunity to send an important communication to a sibling. ("My weight loss from bulimia dropped my weight lower than my sister's. I could finally beat her in something.") Yet still other women make a connection between the bulimia and their siblings in the process of their getting better. ("If I get better and no longer have a serious problem, I will grow beyond my brother who is still mixed up.")

Certainly the level of consciousness about the messages is a fertile area for further exploration. While the messages are not explicit, often the women are consciously (or pre-consciously) aware of them; some people seem to need very little prodding to recognize the meaning of their symptom, while others tightly defend against knowing it.

Some of the limitations to this study also suggest important areas for further research. Do these same messages get expressed for other symptoms, such as depression, suicide attempts, out-of-control behavior? Are messages more likely to be expressed through symptoms at a certain age period--childhood, adolescence, adulthood? Are these messages a result of the type of program, e.g., would a non-residential program for bulimia elicit the same type of messages?

Clinical Implications

Siblings are more than just part of the family; many hold a special significance by virtue of their position as both peers and relatives. Siblings are clearly important in the inner world of some women. The results from this study, therefore, suggest some implications for clinical practice. The most important one is that therapists should ask about a woman's brothers and sisters. How many siblings does the woman have? What is their birth order? What is each currently doing? How is each functioning--in relation to parents, work, friends, lovers or spouses? What is their relationship with each other and has it changed recently? Have their been any major life crises or changes for any of the siblings? What was happening for each of the siblings around the time the bulimia began? Siblings may not be important to all women with bulimia, but a therapist may be missing important information by not inquiring about the siblings. Focusing only on the mother-father-bulimic woman triangle may be obsuring significant clues that might lead to other avenues for understanding the symptom of bulima.

While inquiring about the siblings is important a second clinical implication from this study is the importance of considering involving the siblings in the therapy. Since siblings can be relevant to the onset, treatment, or cure of bulimia, inviting them to a therapy session may be helpful. There are a variety of ways to

involve the siblings and different reasons for doing so. Sometimes the bulimic woman is aware of a problem with or a concern about a sibling and wants to invite that brother or sister to the therapy in order to resolve the issues. One or more of the siblings may attend the therapy in order to provide another perspective to the bulimic woman´s view of her family and of family events. Older siblings often have a different perspective by virture of their age difference. Brothers and sisters may see issues differently. In these instances, the siblings come as a participant to the therapy or as a consultant to the bulimic woman and her therapist. The meetings can be with all the siblings, or with a subgroup of them (e.g., all females, all over 25 years of age, all the married ones).

Inquiring about the siblings, then, and meeting with them puts the therapist in a better position to assess if there are any sibling communication messages being expressed through the bulimia.

Conclusion

One of bulimia´s fascinations is that "There is something for everyone, from the researchers who like symptoms they can count on to the philosophers who like to analyze society. Consequently, there are increasing numbers of ´blind´ men and women, ourselves included, who

are feeling different sections of the bulimic 'elephant' and giving very different descriptions of what it feels like" (Schwartz et al., 1984, p. 280). This study has been another 'blind' hand on the elephant, and hopefully there will be many more as therapists continue to learn about bulimia and siblings.

APPENDICES

APPENDIX A

ADDITIONAL MULTI-FAMILY THERAPY TRANSCRIPTS

Hing Sue's Family

Hing Sue and Lua are talking together without parents present. Hing Sue talks about how she wants Lua to show more affection. She moves from a matter-of-fact request to a tone of pleading. Lua responds factually by saying, "I talk with you," or "You're never home." She seems to be totally missing what Hing Sue is requesting. As the discussion continues, Hing Sue becomes teary; Lua sits stiffly, with no outward emotion. Therapist asks Lua what she is feeling. She says she does not know. She does not think she is feeling anything now.

Hing Sue (bitterly): Don't you ever feel anything?

Lua (flatly): I don't think I do.

Therapist: Are you worried about your ability not to feel things?

Lua: For a long time I've felt there was something missing. I don't know what it is, though.

Hing Sue: Do you think you never felt anything, or you shut off your feelings when I became anorexic?

Lua: I don't really know. I have wondered that myself, but I don't know.

Hing Sue: I have worried about you for years. I remember when we were real young, you seemed so different. I have worried that I was the one that caused you not to feel things, because you always seem so remote, so uncaring. But I have also had the feeling of being a diversion. Maybe I was trying to take the focus off you. I didn't know if I caused you to have this...emotional void, or if I was protecting everyone from noticing it.

At the end of the multi-family therapy, Hing Sue tells the therapist,

Hing Sue: I was surprised. My sister was practically dragged here by her hair. When she left she said she was glad she came. We had two meals together; it was the first time we had gone out together in a long long time. I spent all the breaks with her, and we talked. I was really comfortable with her

and we even talked on the phone later. It's true that during those five years I was sick, I never even tried to turn to her because I was afraid she would either reject me or not understand....I felt like I really shared with her [after her next binge and purge]. I took her in to my confidence for the first time about having a binge. I was really surprised because instead of slamming the door, she really listened to me.

Below are examples from the Multi-family meetings of the other ITP groups. These give a range of the interchanges dealing with siblings. The examples show how what happens in between siblings in one family can have an effect on another woman dealing with her siblings.

Denise, a 35 years old, married woman, has been anorexic and bulimic for 17 years. She is self-conscious about everything she says and does. She is totally wrapped up in her own incompetence and acts phobic of touching others. Denise is the oldest of three girls: Paula, aged 33, is mildly retarded although the family has never openly acknowledged it; Joyce, aged 31, functions as the healthest, looking as if she has her life together.

Denise is talking to her sisters in an exercise where she is to tell each of her family members why she needs them here for the MFG, and what she hopes to work on during these two days. The family members can not respond at this time.

Denise: The role I took in the family when we were all home was taking care of you two. Mom was drunk so I was needed to be in the caretaking role. But I no longer need to do that. I need to learn new ways to relate to you now. Joyce, I need to stop seeing you as so strong and always in control; we need to be able to share together. Paula, I do not know how I'll do this with you. I do not want to relate to you as a parent. I just want to see you as an adult.

In a later exercise, all the siblings of the bulimic women are in a group together, talking about what it is like having a bulimic sister.

Joyce: She's been struggling for 17 years. I have lots of resentment. I want her to get it together, to get over this. I worry, though, that it may be hopeless; she may never change.

Paula: I don´t think it´s hopeless. I think she´ll get better.

Therapist (to Paula): How do you understand that after 17 years of bulimia and therapy that she hasn´t gotten better yet. What do you base your hope on?

Paula: I don´t want to give up hope. I´m not angry, I´m upset that she has this problem."

LATER, all the families are sitting together, and Denise and her sisters are talking about their worry about mother´s drinking, that the parents do not have any relationship together, and if things change too much in the family, parents may end up divorced. The therapist asks if they are worried about someone in the family.

Denise (in an unusually firm voice): I´m worried about Paula. That you won´t have a life of your own. Mom and Dad won´t be here forever [she lives with them]. Your relationship with them may hold you back from doing things for yourself. You worry about them too much.

Paula: They don´t hold me back.

Denise slumps in her seat, saying nothing more.

Therapist: This happens in the Group, too, Denise. You say something, and if it doesn´t get validated, you go dead. Do you really believe what Paula says? Tell her.

Denise (firmly): You are 33 years old and you live with Mom and Dad. They always say you can´t live on your own. You have become Mom´s companion; Dad isn´t. I worry that you don´t have much of a personal or social life. It makes me feel responsible for you. Like I must help fill your life, or something, for you.

Joyce confirms Denise´s comments. She talks about how Paula and Denise have been a burden to her, worrying about them not getting on with their lives.

Joyce: Fortunately, when Denise got married, Paul took that one off me--well, somewhat.

Therapist (to Joyce): It would be nice if you had a sister that was not a burden to you, who could give back to you.

Joyce cries, and Denise gets up and comforts her.

Joyce: I hate it so much.

Therapist (to Joyce): They suck you dry?

Joyce: I wish everyone would get their act together and leave me alone...but I don't really want that.

Therapist: You want a give and take? What did it feel like to have Denise give you something now? She gave you her opinion and some nurturing.

Joyce: I know Denise took care of me as a big sister, but I rebelled against that role.

Therapist: You want a sister now, not another mother?

Denise: I know that <u>now</u>.

At that point, another ITP'er speaks up, talking to her brother. Clair, an exceptionally shy and withdrawn 25 year old married woman has been anorexic and abusing laxatives for 7 years. She is the middle of three children, the only female. She speaks to her younger brother Dick, aged 23, who is still single, spends all his free time at their parents' home, and who is in a dead end job.

Clair: I worry you can't show any emotion. None of us can, but you more so than any of us in the family. I worry you'll be all alone. I wish you didn't keep everything inside. Are you worried about being alone, too?

Dick says nothing, and after a long silence, the therapist asks him if he can respond to his sister.

Dick (to therapist): I don't think there's anything for her to worry about.

Clair: We just don't show any emotion in our family. We don't share things. This is hard.

Therapist: Is there anyone else who is worried about Dick?

This opens the door for both mother and father to speak of their concerns. Later, back in the Group, Clair becomes aware that she does have many feelings, but that she has always felt weird showing it. The bulimia numbs her feelings--about herself as well as her worry about Dick. (More information about Clair can be found in Chapter 5.)

APPENDIX B

Additional Genograms

Marsha's Family

Marsha aged 18, is the third of three children. Her older sister, Rosie, aged 26, is a Ph.D. and her brother, Paul, aged 24, is an M.D. Marsha, younger than her brother by 6 years has dropped out of college and wants a non-professional career. Her sister and brother are both tall and slender, strikingly attractive. She is built stockier than they, and is of average looks. Their differences are obvious when meeting them. In personality characteristics, interests, and physique, there is little that is similar. When looking at the genogram, then, it is not surprising to see that the only overlap is in their mutual concern about body image. One of the categories of messages Marsha is sending to her siblings is "I'm not as good as you." This is the one message under the "Other" category. (See Figure 2.)

Nora's Family

Nora, a 27 year old woman, the second of 8 children, has a striking difference in her genogram. Nora's main struggle during the program was to accept the fact that she may be emotionally healthier than her siblings. She talks about how difficult it would be, how she would feel so different if she did not have a problem (since they all have serious ones). On her genogram, she is the only one of the 8 of them, including her 12 year old brother, who is not identified as having a drinking problem. They are all circled in orange (drug and alcohol problem). Nora has orange around her, too, with a note stating "bulimia." By having the bulimia she can be seen as being one of them (connecting). (See Figure 3.)

Darlene's Family

Darlene, aged 18, is the youngest of 5 children. The oldest is a female, the ones in between are males. In the Family Seminar, Darlene said, "The boys are powerful, rich, strong. They have no problems, and a strong work ethic. They succeed; they are my kind of people. The females always screw up." Her mother used to be alcoholic, but three years ago she went dry, and now she is "a born again Woman's Libber....I don't pay any attention to her. Phyllis is the smartest, but she fails her classes. She is always getting in trouble....When she comes over, the rest of us always ask what her mood is, for that sets the tone of our visit. She used to be bulimic--when I first was anorexic. Someone needs to help Phyllis who always screws up." In tracking Darlene's evolving eating disorder, it becomes clear to her that she periodically takes the heat off Phyllis. "Phyllis is our family's Town Drunk [referring

to Mark Twain's phrase that the Town Drunk is an elected position and that most families have one]. But sometimes I become it, to give her a break." In looking at her genogram, it is striking to see that along the sibling line, the most colorful people are the two on the ends--the oldest and the youngest--Darlene and Phyllis. The three boys look squeezed in the middle with only orange (for alcohol) around them. The categories of messages that Darlene is sending to her siblings are deflection and equalizing. Phyllis seems to be getting the equalizing message and the boys' alcohol problem--which was never mentioned during the program--may be being deflected through her attracting attention to her bulimia. (See Figure 4.) For further information on Darlene, see Chapter 5 and Appendix C.

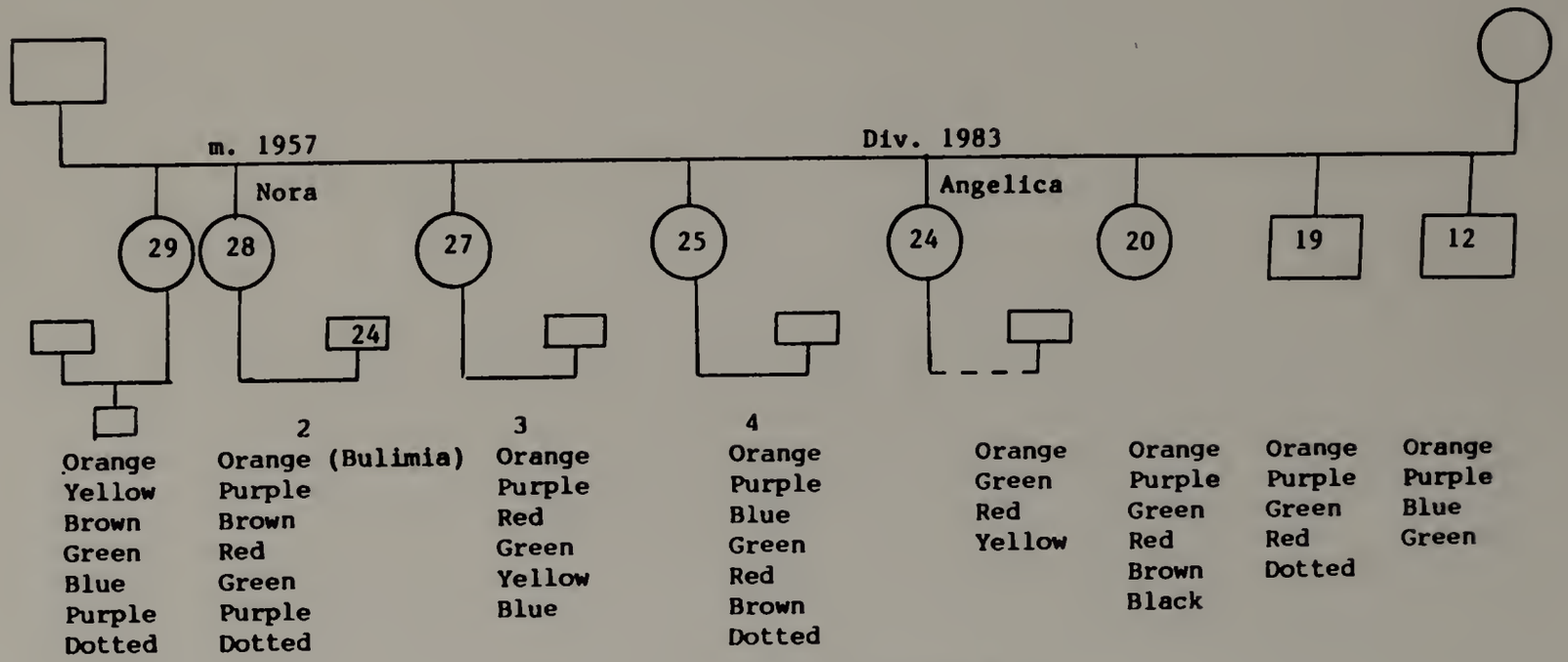

Figure 2: Nora's Family Genogram

Note:
There are 10 oranges. Nora is the only orange that is not alcoholic. There are 8 purples, representing separation.

Color Code

Orange-Alcohol or Drug Addiction
Purple-Separating Issues
Green-Conrolling (Overt or Covert)
Blue-Peace At All Costs
Red-Freely Express Anger
Yellow-Sexual Issues
Black-Health Losses
Brown-Body Image Issues
Dotted Black-Perfectionist

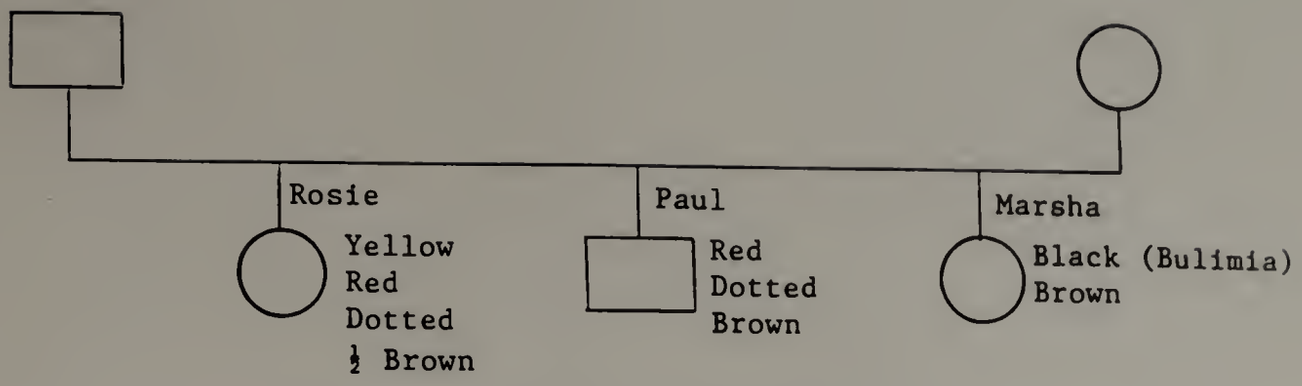

Figure 3: Marsha's Family Genogram

Note:
The only colors Marsha shares with siblings is brown.

Color Code

Orange-Alcohol or Drug Addiction
Purple-Separating Issues
Green-Conrolling (Overt or Covert)
Blue-Peace At All Costs
Red-Freely Express Anger
Yellow-Sexual Issues
Black-Health Losses
Brown-Body Image Issues
Dotted Black-Perfectionist

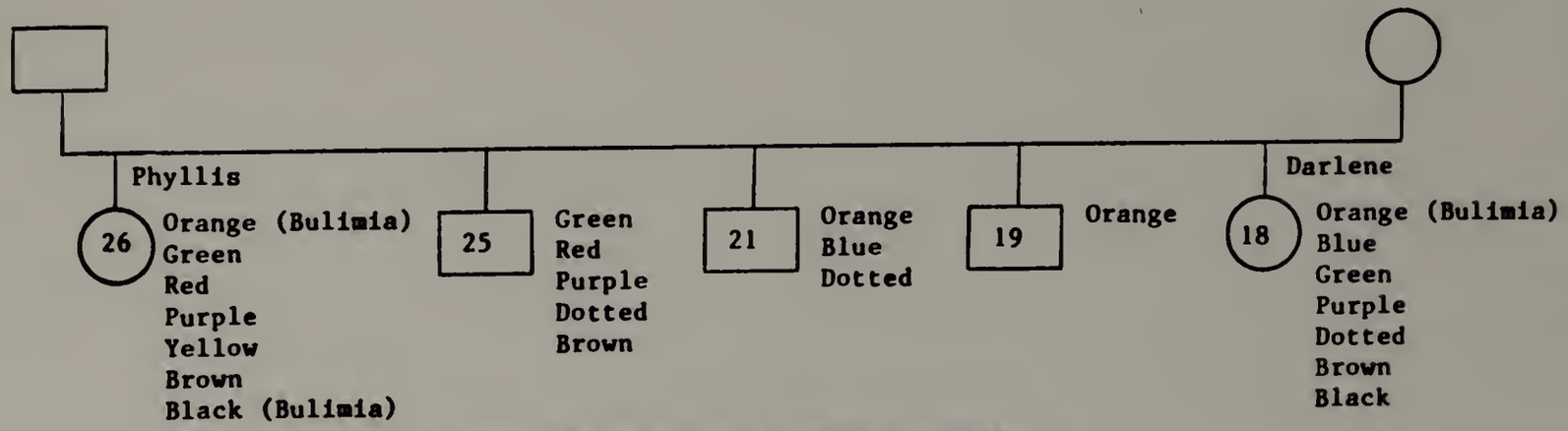

Figure 4: Darlene's Family Genogram

Note:
Phyllis and Darlene's orange represent bulimia while the 2 younger sons' orange is for alcohol, which was never discussed in the multi-family therapy.

Color Code

Orange-Alcohol or Drug Addiction
Purple-Separating Issues
Green-Conrolling (Overt or Covert)
Blue-Peace At All Costs
Red-Freely Express Anger
Yellow-Sexual Issues
Black-Health Losses
Brown-Body Image Issues
Dotted Black-Perfectionist

APPENDIX C

Clinical Examples for Each Message

Equalizing and Connecting

Since these two messages are often used together, an example is selected that shows how bulimia can serve this dual purpose.

Ann, age 22, was the youngest of four children. She had been bulimic for 6 years. She was ready to get better but felt there was something that prevented her from finally stopping. She said her older sister, Carol, had been anorexic for several years; her second sister, Mary, used to be alcoholic and had always been weight obsessed. She said her brother Hugh had a serious drinking problem. He had physically abused her for many years when they were younger. Her parents did not see the abuse. Father, president of a large corporation, was absorbed with his own drinking and Mother was preoccupied with not noticing it. Both parents themselves were terrified of the brother. They never knew what to do when he threw things across the room or threatened to harm them.

During the first week in the Group, Ann talked about the importance of dieting in her relationship with her sisters.

> Ann: It was the only thing we had in common. We always talked about our newest diet, how much weight we were losing. Even when they moved out of the home, it was the one topic we could always talk about.

The therapist asked what the sisters might have talked about if they had not been talking about dieting.

> I don't know. We certainly couldn't have talked about Dad's drinking, or how scared we were of Hugh. I don't know, but we never had to find out.

Ann had contacted each sibling directly, trying to get them to come to the multi-family therapy. The night before the following Group exercise, Ann learned that her parents had called the siblings and had told them not to come. Ann was furious. In Group, she talked to empty chairs representing each famiy member.

> Ann: I want to talk to my family, but it's too late; none of them will be coming, just my parents. It's too late 'cause I'm too old and I'm not sick enough any more. It's not important enough to my brother and sisters.

Therapist: Even though it's too late, whom do you want to talk to?

Ann: Well, my brother. [She alternates between talking to him and talking about him. The change does not seem significant.] You made me feel so bad. You told me I was ugly, and you told me I was fat. You told me I was a piece of shit. You used to beat up on me, and nobody cared. Everyone was caught in their [sic] own bickering. You still do it. You think it's cute. You think it's your job to tell me what I should be. And no matter what I am, it's not good enough for you. I'd like to kill him for what he did to me. I want to hurt you. I don't know why Mom and Dad didn't see what really happened. Everybody pretends it's one thing when it's another thing. I don't want you to feel bad. You never feel bad. I want you to feel something.

Ann then prepared to talk to her older sister who was anorexic. The famiy denied it; they accepted her words at face value--that she was just never hungry and just naturally thin. Carol had been Ann's protector when they were younger and parents had not been emotionally available to the children.

Ann: We always dieted together. That was the one thing we had in common. But now, no one's gong to help you. You're gong to die and eveyone's just going to let you go. If you come [to the MFG] you'll see everybody else here [the bulimic women] and maybe you'll see what's wrong with you. Maybe you'll want to do something about it.

During the next week in Group, Ann said,

Ann: If I get better, I will be the only normal or well one in the family. I've always felt left out as the youngest, but then I would be left out for sure. I'm not sure I want to get better.

By the last week, Ann was saying,

Ann: I have to get better, even if it means leaving them all behind. I used to want to get better if it would help Carol. Maybe I even got sick to help her see what she was doing, or to get my parents to see. I don't know, but I have to get better now, regardless what happens to them. But I worry. I won't have anything in common then, with any of them. I don't really care about my brother, but Carol and Mary and I, that's all we talk about is weight. And I do love them.

Dirty Fighting

In Group on the third day, the women were still learning about each other's family. The topic of weight had been raised. Michelle, aged 27, was talking.

Michelle: I have two older sisters and a younger brother, but I was the biggest of all of us, and everyone would think I was the oldest. Whenever we got hand-me-downs, I got the largest clothes....I remember being teased and compared to my brother and sisters.

Group Member #1: Are your sisters overweight?

Michelle: They're not. They are both about 105 lbs.

Group Member #2: Then you've got them beat!

Michelle: No, I do. Yeah, right.

GM #2: Were you always competitive with your sisters?

Michelle: Well, one is two years older and the other is one year older. So we were all in school together. We were cheerleaders together and the whole thing. But, I'm probably more competitive with the one who is one year older, Jill, because we had more classes together. I think we used to compete for grades a lot.

GM #3: What did you win in?

Michelle: In high school she definitely won in popularity. She really had a lot of girl friends and boyfriends. My other sister, Helen, was a perfectionist, a little miss homemaker; she always does everything right. Always dresses perfectly.

Therapist: What would Helen say and what would Jill say if I were to ask them how you win over them?

Michelle: They'd probably say grades or weight--one or the other, I guess. Well, I guess they wouldn't really consider that winning.

GM #1: But it was to you.

Michelle: In high school, I think so, yeah.

GM #1: Who are you beating now?

Michelle: I guess I've set it up in my mind--don't go over 100 lbs. I don't know if I'm beating a number or if....it's just...

Therapist: Who's next to you in weight?

M: I'd say both of them. I'm not sure. they're both probably about 105 or something like that.

Therapist: So damn if you'll go over 100? Going over 100 is too much leeway that they could slip down?

Michelle: Yeah.

Therapist: Do you openly fight with them about anything?

Michelle: I don't think so. No.

Flagging

In group Jeanne, age 20, was talking about her family. Her parents' marriage had always been terribly conflictual. The worst part for Jeanne was not only that she was put in the middle or accused of siding with her father, but her mother was very possessive of her last child, e.g., calling her daily at college. Jeanne's older sister and brother never returned home after college. Jeanne took a leave of absense from college to deal with her bulimia, and was living with her mother until she entered this program.

Jeanne: Since Dudley left for college I have tried to stay away from their [parents'] battles. Everytime Mom tries to interfere with my life I get really angry....I guess Dudley and Arlene would condemn me for that. They moved away, but I don't think I should.

Therapist: So, it'd be worse to leave your mother--to move out--than to continue to live with her?

Jeanne: I wish there were a middle ground. I don't understand because my brother and sister seemed to be able to deal with leaving her.

Two weeks later,

Jeanne: It's not fair. Arlene and Dudley both moved out and passed on the responsibility for taking care of Mom and of watching out for the two of them [parents] to the next one in line. And I have no one to pass it on to. So I'm stuck here.

The last week of the program,

> Jeanne: Since the MFG, Arlene and Dudley have agreed to be of more help. They both call me more now and we talk about how difficult it is for me to get free. We have begun to talk about the advantage of Mom and Dad divorcing, which I don't believe they will ever do, but at least they [my siblings] are aware of how difficult it has been for me, and how bad it really is between our parents.

In the follow-up questionnaire a year later, Arlene wrote, "The family meeting stirred up issues that needed to be dealt with."

Deflecting

In the family seminar, the group discussed Mark Twain's comment, "The Town Drunk is an elected position." The question was raised whether that phrase was applicable to bulimic women. Were they the Town Drunk in their family, the sick one? Was it an elected position?

> Darlene: My sister is more of the town drunk than I am; she's been at it for ten years, and I've only been bulimic for 4-5 years.
>
> Therapist: What happened 5 years ago that she moved over and gave you room?
>
> Darlene: She went in the hospital and started to get better. Ohhh! I don't know how that...I don't think that has much to do with it. I have not been the continuous thing for 5 years. For two years, then I went in the hospital and got better, till I came here. Between those times, I don't think it was necessarily me....When my parents are having tension with her, I come in the room and change the subject, saying something like, "Let's make dinner."
>
> Group Member: You said before that you always take care of your sister because she's always the one in trouble. It's as if you say, "OK Phyllis, you can leave and I'll take the spot, so you can get out."
>
> Darlene: Well, heh, heh, heh. I called her last night. I think everyone's been mean to you, I said, and I always try to take care of you.

Darlene listed the roles in her family.

> D: Phyllis is the black sheep and the town drunk. Everyone always worries about her. She's always causing trouble. The whole family evolves around

her mood. I'm the caretaker. [She gives an example of how she jumps in to protect a brother] which keeps him from having to take care of himself.

Th: If you were to step out and say, "No way; I won't be a problem for the family," who do you worry would come in?

D: [Without hesitation] Of course, it would be Phyllis.

Using an abstract drawing the women were asked to construct their family showing the alliances. Darlene puts the males on one side, her mother and sister on the other side and herself--drawn larger than all the others--in the middle. In describing the drawing she said the males were powerful, rich, and strong; the females were weak and had problems. She talked about her mother and then said of Phyllis,

D: She always screws up. Someone needs to help her. I'm the one trying to keep everyone together.

A group member asked if Darlene helps Pyllis by getting her off the hook, by Darlene becoming a problem? Darlene gave a silly grin, as if caught, and said, "Ohhh Nooo!"

Another example of Darlene can be found in Appendix B.

Separating

Maria was a 27 year old married woman, and the youngest of four children. Her father had died about 15 years before, just prior to her bulimia starting. She lived in a town 15 minutes away from her two brothers who continued to live with their mother. Maria has refused to invite any family member to the MFG despite the therapists' strong recommendations. She wanted only her husband to be there. Yet in Group, Maria spent most of her time talking about the problems she has with her family members. She would visit her mother and brothers at least once a week and talk on the phone several times a week. Maria told the Group that her older brother, Tony, aged 31, was deaf, still living with mother and although working, he did not have much of a social life. Her older sister, Anna, aged 30, was married to a man who had molested Maria a few years ago. Maria did not like Anna; she thought Anna used everyone in the family. She thought Anna was always causing trouble for mother and then Maria would be called in to morally support mother during these battles. Seppi, the younger brother, 28 years old, was socially backwards. He did not work and never went out, spending most of his time on the front stoop in the rocking chair.

During the MFG, in an exercise where the women tell their family members what they need from them, Maria talked to her family through empty chairs. Using sign language, she told Tony,

Michelle: I want you to grow up. Be a man. You're 31 hears old. You act like a baby. You will never be free if you stay here and let my mother be

everything for you. Religion is not the only answer. You have to live now.

To Anna, she said,

Michelle: You bailed out of every crisis we ever had. You use the family for everything you can get. I've had to sacrifice a lot of my life because of you. I still love you. I wish you could experience more of what you feel.

To Seppi, she said,

Michelle: You always felt you had to be the man of the house and take the role of Dad. You shouldn't have done that. You can't really handle it, even though you think you can. And I wish you'd stop living in a dream world and learn to live with reality better. I wish you wouldn't go into yourself so much.

During the rest of the program, Maria learned to trust the other women. She learned how to share things besides problems, and she learned that others do not need to use her for their problems only. (These were issues she said that had always existed in her prior relationships.)

By the last week, it was clear to the therapists why Maria had needed to exclude her family from the MFG. She came from an Italian family where togetherness was highly valued.

Michelle: I am really conflicted. My sickness gives me some distance, but I am letting everyone down. As a good daughter and sister, I should be at the house taking care of them all. That is what my mother did when she was younger, and that is probably what my father would expect of me if he were still alive.

By being sick, she could do both; she could take care of them, but because she was sick she could also escape them by pulling into herself.

Peacemaking

Irene, aged 19, was the youngest of three siblings. Her older sister, Marilyn, was identified as "the perfect one"; her older brother, Len, was always a more difficult child for parents than his sisters. Just before Irene's bulimia started, Len had had a serious car accident in which he suffered minor brain damage. His behavior since than had been erratically mean. Parents attributed the meanness to the effects of the accident.

In group, Irene acted very young for her age, and rarely initiated any discussion. One day though she talked about Len's accident.

> Irene: I feel I have to make it up to Daddy--for the loss of his only son. I have to be successful for him.

When the other members asked her more about Len, Irene described his outbursts as verbally abusive and sometimes physically violent. At another time, she said,

> Irene: His only consistent caring towards me has been since he found out I was bulimic.

When Irene decided to enter the ITP, Len's abusive behavior stopped. He had withdrawn somewhat from the family (which was appropriate since he was beginning his own famiy). The time he did spend with them was more enjoyable for everyone. There was less talk about the ill effects of his accident.

APPENDIX D

List of Messages Given to the Independent Raters

The fourteen statements listed below were given to a group of independent raters. They were to assign each statement to one of the eight message categories described in the study: equalizing, dirty fighting, connecting, flagging, deflecting, separating, peacemaking, and other.

1. Before knowing about the bulimia, we hardly ever saw or talked to each other. Now my brother calls frequently to see how I am doing.

2. I felt so bad that my sister never dated in high school. She was very fat and never went out. I was very popular, had lots of friends; I was a cheerleader and on the swim team. She never did anything but stay home and study.

3. It´s easier for my parents to handle my eating problem. They knew what to do about it; I started therapy the week after I told them. If they find out my sister is having an affair with a married man, after my father ran off with another woman, I don´t´ know what they would do. My mother might really flip out.

4. My mother and Jon are on the phone constantly talking about what to do about me once I dropped out of college and stopped going out. They hadn´t talked for ages before all this started.

5. When Carla heard about my suicide attempt, she called Mom--the first time in over a year. She told Mom that she had made an attempt a few years before. Mom now will ask Carla what to do about me, how to handle my depression. It´s nice to have Carla eating dinner with the family again, or just sitting around watching the tube.

6. I feel awful knowing that I was everyone´s favorite. I know my brother and sister hated me for it and picked on me constantly. I liked the special attention from Mom and Dad and the grandparents, but I really felt left out by Cassie and Karl. I would have given up being the favorite if they would have let me in on their secrets, asked me to go out with them.

7. Roberta was always a better student and soccer player than I. I hated it that she always did so well, and she was so stuck up. Now at least she talks to me, worrying how I am doing.

8. When we were little, I worried about my sister; she was so withdrawn. Mom said she was just shy, but I thought there was something missing; she didn't feel things like I did. But then I became bulimic. I was wrapped up in myself, so I forgot about her.

9. I am afraid to give up my bulimia; I might gain weight and then I would be fatter than my sister. This is the only thing I could ever do better than she.

10. I feel like I escaped and left my brother to take care of our parents; I feel real guilty about that. I know he's real sick now, but parents are happy to have him back living with them.

11. I feel deserted by my sister and brother [in caretaking parents]. I call it as it is in the fmaily [sick relationship between parents and mother's laxative abuse]. Everyone else will not see it. They say it's all normal. Well, it's not and I have to get them to see it.

12. My older brother is 31; although he is deaf, he has a job and friends, but he still lives at home. My older sister is a constant problem to Mom--borrowing money; getting in trouble and needing to be bailed out; always screaming. She's just a mess. My younger borther can't hold a job; he sits on the front porch and just rocks all day long. Mom is always calling me to come over and help out with some problem or other. It's been particularly hard since I got married last year and we live in another city.

13. My brother caused so much trouble as a child. I was so good, did everything as I was told. He got all the attention. Maybe I learned that if I want attention, I need to be sick or have a problem.

14. Since my brother and sister have been off at college, I am the only one left to take care of Mom and Dad. They fight constantly. I don't understand how my brother and sister dealt with leaving. I can't; they [parents] would kill each other. Arlene and Dudley each moved out and passed on the responsibility for taking care of the parents to the next. I have no one to pass it on to now. Someone has to do something to help them [parents].

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