FAMILY INFLUENCE IN EATING DISORDERS:
SOCIALIZATION AND FAMILY FUNCTIONING AS RISK FACTORS

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Abstract

Eating disorders remain, for the most part, an enigma, making both prevention and treatment of this potentially deadly mental disorder a considerable challenge. Eating disorders are unique because of their extremely high occurrence in females versus males, with peak onset occurring in adolescent girls. It is logical then to examine how gender factors into the disease.

Women have higher rates of all depressive disorders and food rejection in particular has a long history of occurring in women. There are a number of theories as to what makes women so vulnerable, most pointing to unrealistic expectations or obstacles to success generated by the social construction of gender. These expectations and obstacles can create considerable discord within the psyche of women, a stress which can manifest itself with depressive symptoms like those of eating disorders. In adolescence, girls begin to embody their womanly selves, making the challenges of womanhood seem not only inevitable, but imminent. Compounded by the stress that accompanies pubertal changes, this time can be very difficult for young women leading to many forms of depression including eating disorders.

There are a variety of theories as to how children come to understand gender, its functions, and implications, many of which point to the family as the primary socialization agent in terms of gender. Creating a microcosm of society within the context of the family, a child develops a sense of the way that the world works through the family. Not only do they create this environment in which children grow and learn, but they also provide everyday social interactions, many of which have been shown to be affected by gender of the child regardless of the gender messages that parents want to send. In reality, children are much more similar than they are different, but they will accept the messages that their parents send them. Explicit messages, though, will often override the unconscious ones that parents may send making gender socialization active decision on the part of the parent.

Eating disorders seem to aggregate in families and there is a recurring pattern of poor family functioning. Discourse about weight will increase the probability of disorder even in families that do not have functioning problems but can compound the problem in those that do. Pressures about weight can also come from the media, but the family is in a unique position as they are actually able to mediate the effects of cultural pressures from the media.

Causal models have been unable to describe the course of mental illness; there is considerable disagreement between the cause and effect in many cases and conclusions cannot be confidently drawn from research. It is useful, therefore, to look at the family as a system in order to examine how family functioning affects children in the family. When a system is functioning poorly, it generally manifests itself in its least well member, in this case children with eating disorders. A family system can also, however, be supportive helping children by buffering the effects of stress. This is tremendously important in the case of those who are vulnerable from stresses due to gender or other factors. These individuals will not develop disorder without additional stresses, and family can help buffer those stresses lessening the chance of disorder.

As stated, eating disorders are still very much a mystery, but the family clearly plays a role in creating stress and mediating pressures from the outside world. Both are key components in either protecting a vulnerable individual or creating an environment ripe with pressures that will prey on vulnerabilities possibly resulting in disorder.
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Introduction

Eating disorders, a type of depressive disorder, have received considerable attention in recent years, as the rates of occurrence have seemed to skyrocket, increasing from year to year. This trend has raised concern about these disorders and caused some to label it an epidemic. While most experts believe it has not reached those proportions yet, the extreme health risks that are associated with the disorder make it a problem that requires immediate attention. While there are many types of eating disorders, all do considerable harm to the health of the disordered individual and are potentially fatal. The little that is known about the disorders makes prevention and treatment difficult, so there is urgency in the desire to uncover the causes of the disorders.

The term “eating disorders” refers to a class of diseases that have similar characteristics but are all distinct in their own right. The two that are most widely recognized are anorexia nervosa and bulimia nervosa. Anorexia nervosa is characterized and defined by four characteristics: refusal to maintain minimal normal weight for body size, fear of becoming fat, a disturbance of self-image that causes body image to become linked to self-esteem, and the absence of three menstrual cycles from weight loss (Frost, 2001, p. 14; Robert-McComb, 2001, p. 4-5). Bulimia is characterized and defined by five characteristics: recurrent binge eating; recurrent inappropriate compensatory behavior for the binge eating including vomiting, laxative use, over-exercise, etc.; binge-purge episodes occurring at least twice a week for three months; body shape and weight are crucial in self-evaluation; and these symptoms cannot be simultaneous with
anorexia nervosa (Frost, 2001, p. 14; Robert-McComb, 2001, p. 8-9). If there enough symptoms present to make a diagnosis for anorexia nervosa and there are also symptoms present from the bulimia nervosa list, the diagnosis will be anorexia nervosa. It is not uncommon for there to be considerable overlap of the disorders’ symptoms in individuals who have an eating disorder.

There are diagnoses in two other categories to describe other eating disorders that have symptoms that are different than anorexia and bulimia. “Eating disorders not otherwise specified” is the diagnosis that is used for individuals who exhibit many of the characteristics above but do not quite fit into the diagnosis of anorexia or bulimia (Robert-McComb, 2001, p. 11-12). For example a girl may have many of the symptoms of anorexia but still have menstrual periods, so she cannot be officially diagnosed with anorexia nervosa. In this case she would receive the diagnosis of eating disorder not otherwise specified. Another eating disorder termed binge eating disorder is similar to bulimia without the purging (Robert-McComb, 2001, p. 13). A person will have the same feelings about weight and attractiveness associated to self worth and will binge, but does not participate in the compensatory behavior.

The peak onset of eating disorders is in adolescents, the majority of reported cases are in females aged eighteen to twenty-five (Robert-McComb, 2001, preface). In the period preceding diagnosis, while the disorder is developing into a full-blown disorder, a considerable number of changes that are going on in the lives of girls. They are entering puberty and their bodies are changing as are their social lives, and these changes can be very difficult to deal with while navigating a social world full of pressures.
It is well known that there are considerable pressures on girls and women to be very thin. While the rates of eating disorders among adolescent women are very high, the fact remains that not every girl develops a disorder. There must be factors aside from pressures to be thin and considerable life changes that lie at the root of the problem. Determining these factors is extremely important as treatment and prevention are difficult when etiology is yet to be fully understood.

Unfortunately, mental disorders are not as clear cut as many medical ones. There are not bacteria or viruses to isolate from those afflicted with the disorders, there are only a set of symptoms that were identified above. The challenge has become to identify factors of disease. “Eating disorders ‘aggregate’ in families, and transmission occurs primarily among female relatives” (Striegel-Moore & Cachelin, 1999, p. 97). Identifying the family as a common factor, it is a logical choose it as a variable of interest. The first person to point to the family as the root of disorder was Henri Richardson in 1945. He said that families should be conceptualized as a unit of illness. From this view, some theorists began to look at the family as the root of many illnesses and eating disorders is no exception (Kog, & Vandereycken, 1989, p. 8).

Originally, eating disorders were seen as the result of fundamental parenting failures, not just characteristics of the family unit. The parents who were considered to “cause” eating disorders were those who emphasized achievement, success, conformity, and traditional concepts of femininity and appearance (Kog & Vandereycken, 1989, p.11). The presence of these pressures would result in disorder; the absence would result in no disorder.
Specifically, as with many psychological disorders that are examined in terms of the family, for many years, mother blaming was very much the norm in tracing the roots of eating disorders. Parenting failure was really viewed as mothering failure. Many turned to a disturbed mother-daughter relationship as the cause of eating disorders (Gremillion, 2003, p. 80; Kog & Vandereycken, 1989, p. 10). The mother-daughter relationship was considered to cause an eating disorder single-handedly.

Mental illness is no longer viewed in this manner as being caused by a single factor as an infection or physical disease. There is no pathogenic family unit, parenting or mothering failure, but the disorder can be viewed in another way. While the analogy of infection fails in that there is no single pathogenic factor, it can be useful in another way. When a person grows ill with an infection, the factors that cause the disease have environments in which they thrive multiplying rapidly easily infecting while others are less suitable and make infection more difficult for the infecting agent. For bacteria, there is a temperature, pH, amount of oxygen, etc. at which bacteria grows most rapidly. Rather than causing illness, some families can be viewed as creating an environment in which eating disorders are able to thrive, and other families create environments that make the development of disorder less likely, but not impossible.

This paper begins to examine the type of environments that families create which are most suitable for the development of children with eating disorders. It will specifically examine two ways in which the family helps develop an environment in which eating disorders are more likely. The first area examined
will be how the family influences the development of views about gender in its members and how these different views affect the likelihood of disorder. The other area of interest will be how family functioning affects the same likelihood. These can then be described by family systems theory, specifically risk theory.

Looking at the family as a system can help to identify which dynamics are particularly harmful. As stated above, more popular now, is to look at the entire family’s disturbances. Family histories of depression, alcoholism, emotional disturbance, extreme social isolation have been found to be extremely common in individuals with eating disorders (Killian, 1994). These factors put stress on the children in the family and in certain individuals that stress can combine with other factors and result in the development of disordered eating psychopathology.

A distinctive quality of eating disorders identified above is that those afflicted are overwhelmingly female as opposed to male. This fact calls into question the role that gender plays in the development of an eating disorder. The research in the area of eating disorders is still very young, so many theories about them have not been thoroughly tested and much of information that there is to rely on is simply statistical research. The youth of the research does not disqualify it from interest, however; much of the research may be unsubstantiated, but it serves as a wonderful jumping off point for examining eating disorders.

Some theorize that eating disorders are truly a rejection of femininity by the individual with the eating disorder. The female individual aspires to achieve great things, but encounters society’s stereotypes telling her that only men can
really achieve. As a result, the woman rejects her body because the feminine figure represents traditional, feminine roles in her mind. Sigmund Freud originally noted such achievement-femininity links in some of his patients. With the increase in the incidence of eating disorders in recent years, this observation has been revisited. Silverstein and Perlick’s thesis in their book, *Cost of Competence*, is that anxious somatic depression affects women who aspire to achieve in male fields (Silverstein & Perlick, 1995). In patients with eating disorders, there exists some disconnect between the idea that they are young women and that they can achieve the great things to which they aspire.

Another view of how gender plays a role in the development of eating disorders is that society’s standards for women are such that woman that adhere to them develop characteristics that are also conducive to eating disorders; society facilitates the disease through the creation of this female identity but does not cause it. Women are required to be submissive and self-sacrificing which leads to the internalization of emotions and difficulties. Burying feelings and problems is tantamount to swallowing poison; the eating disorder develops as a coping mechanism for this style of dealing with things (Striegel-Moore, Silverstein & Rodin, 1993). Society requires women to be self-sacrificing in their roles as the primary caregivers and nurturers. This pattern of sacrifice again sets up the eating disorder (Killian, 1994).

As such a critical factor in eating disorders, it is important to examine where the concept of gender comes from and why different individuals view it differently. As it will be shown, the family plays an enormous role in this development. Though providing an environment and social interactions, the
family teaches gender lessons. Children in general will take the views of their parents so the family creates an environment where gender is viewed as one way or another. Whether stemming from the rejection of the female ideal or facilitated by the acceptance of it, society’s standards for women have been theorized to influence the development of eating disorders in a multitude of ways. These theories point to the fact that it is incredibly important to examine gender in any discussion of eating disorders.

In terms of the second area of interest, a pattern of poor family functioning has been noted in the families of those with eating disorders. There are several traits of poor functioning that have been specifically noted in eating disorder families: enmeshment, over-protectiveness, rigidity, lack of conflict resolution, and involvement of the child in conflicts between parents (Clopton, Haas, & Kent, 2001, 166). These prove to be symptoms of a family system that is not functioning properly.

Another pattern in eating disorder families is that there is often a discourse about weight in some form. It could be focused on the mother, the children, or weight in general, but the presence of the discourse itself is significant. This is also a component of the family environment that could contribute to eating disorders. These factors begins to paint a picture of an environment that is suitable for the development of eating disorders emerges. An environment with these factors composes a situation with considerable risk. Like a person with a compromised immune system, if a person is in this environment and are vulnerable, they are more likely to develop an eating disorder. The vulnerability is the root of the disease, but it is more likely to infect when there is
an environment of stereotypical gender roles, poor family functioning, and discourse on weight.

All of these factors may never result in disorder, but if an individual is vulnerable, a family situation with some of these factors could make avoidance of disorder more difficult. By describing the family as a system, the role of vulnerability and risk can be described more clearly and the role of the family better defined.
Chapter 1

Gender and Eating Disorders: The social construction of gender as key variable

Many signature symptoms of eating disorders have a long history of occurring primarily in women while not in men. There is additional evidence that gender role stress may play a role in the development of an eating disorder when one looks at when the disease has appeared on the medical “radar.” Anorexia nervosa was first named as a disease in the 1870s during the Victorian era, when gender roles were at perhaps their most rigid, but the rejection of food is a phenomenon that has affected women much longer than it has been studied as a mental disorder. There was considerable evidence of girls starving themselves before the Victorian era. While the name did not exist until the 1870s, the unofficial name for these women was “fasting girls” (Brumberg, 1988, p. 61).

Female religious figures, some of whom were later canonized as saints, would starve themselves and it was considered to be very pious and holy. There is evidence of many female saints having practices self-starvation in the name of their religion. Interestingly, though, the same pattern is not found among male saints (Brumberg, 1988, p. 39-55). Male saints are arguably just as pious as female ones, so gender is a very logical variable to examine when studying eating disorders.

Another factor in choosing gender as an area of scrutiny is, as mentioned previously, that mental disorders occur in women more than men as determined
by utilization of mental health services (Travis, 1988, p. 34; Rollins, 1996, p. 238). This discovery has led many researchers to inquire as to what makes women more susceptible. In looking at the connection between gender role and depression, it has been determined that women who score high in femininity on the Bem Sex Role Inventory are more likely to be depressed than those who do not, masculine and androgynous individuals having very low rates of depression (Rollins, 1996, p. 243). The more that a woman adopts a “feminine” personality, accepts social ideals, the higher the chance is that she will experience depression. This logically leads to an examination of how social ideals of femininity affect women.

The feminine role is one that is traditionally far more restrictive than the masculine role in terms of trying to achieve and be successful. There are more barriers for women in the workplace. Many of these are based upon stereotypes, but the basis of the obstacle does not undermine its power. These barriers or restrictions are often correlated not simply with women, but with feminine tendencies or attributes. A feminine style of interpersonal relations for example is often viewed as inferior to a masculine one. Trying to maintain femininity and trying to achieve success are often perceived as incompatible. Attempting to sustain both can lead to considerable stress which also contributes to increased rates of depression in women. Women who are feminine and try to be successful, feminine women do in fact exhibit higher rates of depression (Rollins, 1996, p. 238).

Stress is theorized as leading to eating disorders because of the effects that it has on women. “Disordered eating is often an unhealthy attempt at coping
with stress” (Robert-McComb, 2001, p. 4). Just as stress from gender roles can cause depression, the inability to deal can cause an eating disorder as a means to relieve the stress.

One of the first looks at this phenomenon was written by Betty Friedan in 1963. She described “the problem that has no name” in her book *The Feminine Mystique* and truly opened people’s eyes to the possibility that there could be a problem with women. This problem that had no name afflicted housewives who were not fulfilled by cooking, chores and the other duties of being a wife and mother. While these women seemed to be living the American dream adhering to society’s ideal for women, they were seeking help from mental health professionals in droves (Friedan, 1963). The problem had no name because there did not seem to be anything that should cause such depression in these women. With non-specific symptoms and unidentified causes, a name could hardly be created. They were indeed depressed, however, and Friedan attributes it to the differential between what society tells women will make them happy and what indeed will bring them fulfillment. She opened the door to the idea that not living up to one’s potential can cause mental illness and this insight revolutionized the way that Americans viewed mental illness. That the source of the problem stem from social or societal causes was unheard of at the time of publishing.

In her article, “Silencing the Self,” Barbara Jack suggests that it is the unreasonable standards that women feel they need to live up to that cause them to suffer from depression. In our society, women are socialized to believe that they need to be self-sacrificing and put themselves last. This exists in sharp
contrast to the drive that they feel psychologically to fulfill their own needs. The discord between these two sets of feelings is what Jack proposes leads to the increased incidence of depression in women. She studied the way that women speak about their depression and found that these conflicting feelings are expressed in their descriptions of their lives (Jack, 1991). The woman will state how she honestly feels and then almost immediately state what she “should” do in the next instant. The “should” represents what society tells her that she needs to do, a pressure that remains in spite of her personal desires that are discrepant.

That this is noted specifically in depressed women strengthens the claim that social pressures aside from weight contribute to mental illness. This conflict appears also in situations when women want to attain what they are told they cannot. This conflict can lead to stress which has been identified as a risk factor for eating disorders.

Growing up being told in countless ways that women are supposed to act one way, girls develop expectations for themselves that are often unattainable. This is evident in the “superwoman” construct. The “superwoman” is the woman who can have both a career and family, negotiating both successfully and without any difficulty taking care of anyone else first. The superwoman can easily be a successful career woman and doting wife and mother (Jack, 1991). While it is nearly impossible to successfully achieve this ideal of sheer perfection in every domain, women continue to consider it a standard, as the bar for which they are supposed to be striving. Falling short is in any way, shape or form at work or at home is viewed as failure. These increased demands are considered possible causes of the increased incidence of depression in women (Jack, 1991). Men do
not have the same role stress because they are not expected to be perfect husbands and fathers the way that women are. This lack of stress could reasonably be associated with the lower rate of depression among men.

Brett Silverstein and Deborah Perlick explore the repercussions of this for eating disorders in their 1995 book *The Cost of Competence: Why Inequality Causes Depression, Eating Disorders and Illness in Women*. They claim that it is the obstacles that are placed in front of women in their attempts to succeed that cause them to develop both depression and eating disorders. As examples of achieving women, Queen Elizabeth I and Queen Victoria both were women who were in a tiny minority of females as heads of state in their time. Silverstein and Perlick use historical accounts of these women’s along with similar others’ noting a commonality between all the accounts of depression and mental illness, even eating disorders. They draw a direct connection between the conflicting roles that the women had to take on and their depression. While the women were not held back from succeeding in the way that many other women of their era were, they were faced with a dilemma that those same women were not faced with as well. They were asked to maintain their femininity all the while successfully navigating a world that punishes them for doing so. While not feeling the stress of attempting to succeed, there is pressure from trying to prove one’s capabilities in spite of gender.

Currently, women who have careers and families are less likely than their husbands or partners to feel that they are doing well at both, more often feeling that they are inadequate wives and mothers or that they will never achieve their career goals (Silverstein & Perlick, 1995). Having accepted society’s
“superwoman” ideal, their frustration is focused inward for it must be a personal deficiency that is preventing them from being better. This sense of failure leads to the development of depression and is further evidence that stress brought on by gender role leads to depression. This same stress can lead to eating disorders if an individual is unable to deal.

When examining eating disorders, the population of interest shifts from adult women to adolescent girls as this is the time of most frequent onset. While parallels can be drawn between the two groups’ experiences, there are key differences in what is going on during these periods. There is a sharp rise that is seen in the frequency of both depression and eating disorders when girls reach adolescence. Silverstein and Perlick theorize that it is because girls begin to embody their female self during this period with the changes from puberty and menarche, this embodiment changes their view of their own gender. The girls are made more aware of their female body during this period and so begin to sense the stress that comes with it. They are beginning to sense that their achievements could be curbed by this development. (Silverstein & Perlick, 1995). Aware of the obstacles that women face in trying to become successful and girls who are becoming women can no longer reject what challenges lie ahead. This acceptance of this fate results in various forms of depression.

Silverstein and Perlick go on to show that phenomenon is seen more often during periods in history when women are able to achieve more than their mothers. With no example of a female high-achiever the weight of trying to do what you are told you cannot is considerably more than if there is a role model or example of such success. During periods where women would have had the
chance to rise above the position of previous generations of women, there is trend towards higher numbers of women with depression. This is one of the reasons that most recently such trends are observed; women have more opportunity to excel now than they have experienced at any other point in history (Silverstein & Perlick, 1995, p. 151).

Kim Chernin, a psychoanalytic theorist, also looked at the idea that the daughter’s relationship with the mother is the source of an eating disorder. Instead of looking at role stress, she believes that it is a daughter’s guilt over trying to surpass her mother that results in the development of an eating disorder (Brumberg, 1988, p. 30). Whether overwhelmed by guilt or feelings that one is trying to achieve the impossible, a clear link exists between how a daughter views the mother and how she comes to develop an eating disorder. As a coping mechanism, the eating disorder helps the person with the disorder deal with the guilt.

Again, it is mainly women who suffer from these diseases which raises the question of how gender functions in terms of causes of the disease. As previously discussed, the more feminine a woman is, the more chance she has for depression. “Stereotyped female identity contributes in negative ways to the establishment of autonomy, competence, and an independent sense of self” (Worrell & Todd, 1996, p. 152). Due to the female identity of these women, they are lacking in many important areas for the development of good self-esteem. Not feeling capable of doing things independently and performing independent tasks as successfully as desired can lead girls to have a poor self-image something that they try to ameliorate through eating disorders. The eating disorder restores
a sense of autonomy and control that is lost with the adoption of a stereotypical female identity.

While the link between body image and competence may at first seem a leap, in reality women are not totally off base by choosing their bodies to attack when they feel incompetent. Women are more successful when they are attractive, and unfortunately women are acutely aware of this harsh reality (Worrell & Todd, 1996). To attack attractiveness may in fact be considerably easier than attacking other aspects of perceived competence. By making themselves more attractive, they may in fact become more successful which can only worsen the problem, reinforcing that it is appearance that will lead to success.

An eating disordered individual’s feelings are expressed symbolically through the eating disorder behavior; the behavior is only the visible manifestation of a much deeper and greater problem (Brumberg, 1988, p. 2). “Today’s anorectic is one of a long line of women and girls throughout history who have used control of appetite, food, and the body as a focus of their symbolic language” (Brumberg, 1988, p. 2). Both in treatment, assessment and research there is a need because of this underlying cause of eating disorders to look beyond the symptoms to try and discover a different source of anguish being expressed symbolically with food. Women are trying to deal with their stress, so they take control of food to cope.

It would seem, then, that women of all ages would be suffering from these diseases if it is simply a product of adopting stereotypical gender roles. While women of all ages can develop these diseases, they do not do so with comparable
frequencies. Instead, girls entering adolescence are developing the disorders at astounding rates, far outnumbering their older or younger counterparts. Adolescence is a time of considerable change, and especially great changes are seen in the areas of gender identity with the growth of breasts and menarche. These changes spur on some of the feelings that set the stage for mental illness. “During developmental periods of change or uncertainty for girls and women with respect to their gender roles and gender identity...these developmental paths contribute to stress and distress” (Worrell & Todd, 1996, p. 152). With the influx of hormones at puberty, the beginning of adolescence, it could arguably be the time of largest change and uncertainty for gender roles and identity precipitating in the stress that can be so harmful to young women. These changes add to the stress of everyday life, a stress that can be very difficult to deal with, and for those susceptible to eating disorders, it becomes too much.

According to this information, those accepting traditional gender roles during adolescence are at most risk for eating disorder. The acceptance of these gender roles is not, however, inevitable so it is important to examine what makes individuals accept one type of gender role over another. There are many theories as to how children learn about gender and understand it that will be presented in the next chapter. Each relies on the fact that children pick up on cues from the social world to learn about gender regardless of the method by which they are taught.
Chapter 2

Gender Development: An Overview of Theories

Gender and its implications are so ubiquitous that it is easy to forget that gender is a social construct, that it is a human creation. As it is such a part of every ounce of social reality, determining its origin is difficult. There are many schools of thought and even more theories as to how children acquire a sense of what gender is and what it means. There are also a number of views that draw from multiple schools attempting to bring together different concepts of gender development into a cohesive theory.

While there were theories about gender development, there is very little research on gender prior to World War II. Attention increased in the 1950s and 60s then to be influenced in the 1970s by emerging ideas about gender from the mounting strength of the women’s movement leading to more interest (Coltrane, 1998, p. 111). Consequently, while there were ideas about gender there was little evidence to the validity of any of them.

There is little or no consensus about the origins of gender as a construct, but it is necessary to gain a working understanding how it may occur in order to better understand its impact on the development of an eating disorder. Because there are no definitive answers as to how gender develops, it is important to overview many of the most popular theories. It is also important to understand that while there are various theories about the development of gender. The family has a tremendous impact on each proposed situation.
Identification Theory

The first group of theories on gender formation is known as identification theory and these theories assert that children understand their gender as a result of identifying with their parent of the same sex (Brooks-Gunn & Matthews, 1979, p.98). The process of identification leaves children with an “internal parent” that dictates how they act and what choices they should make (Brooks-Gunn & Matthews, 1979, p. 98). Even when they are not in the presence of a parent, children negotiate situations by acting in a manner that mimics what they believe their same-sex parent would do.

Identification theory was originated by Sigmund Freud who developed psychoanalytic theory. Freud’s early theory was based on the idea that children have fears rooted in their gender. For girls, the fear is that they will lose the love of a parent, labeled as an anaclitic (i.e. dependent) identification. Boys, in the Freudian system, have a fear that they will be retaliated against. This is labeled defensive identification. Freud believed that these fears stemmed from the discovery, in the preschool years, that boys and men have penises and girls and women do not. With this discovery, boys are afraid that they will have their penises removed as they presume happened to their mothers and sisters, and girls are upset by the perceived removal of their own penises. Freud believed that this leads to penis envy in women, something that has been unsubstantiated by subsequent research (Brooks-Gunn & Matthews, 1979, p. 105).

According to Freud, around the same time as the discovery of different genitalia in men and women, a sexual attraction begins to grow in children towards the parent of the opposite sex. This is known as the Oedipal Complex in
boys and the Electra Complex in girls after classic Greek figures plagued with these desires. It is in these complexes that the identification with the parent of the same sex is solidified. Girls, having a desire for their father, eventually want a child. Aware that to have a child with their father they must act as their mothers do, girls begin to pay attention to the mothers’ actions and mimic them in an attempt to attract the father. Boys developing sexual feelings for their mothers are torn because to be with their mothers they must eliminate any competitor, in this case their father. They eventually choose to “join the club” rather than complete with their fathers for her affections (Brooks-Gunn & Matthews, 1979, p. 101). Freud personally believed that anaclitic identification did not cause a strong sense of self to develop as the defensive (Brooks-Gunn & Matthews, 1979, p. 102).

Freud’s theories were wildly popular in his time and were widely accepted far into the twentieth century. It was not until the 1970s before they were more widely criticized, researched, tested and found inaccurate. For example children do not appear to discover that there are differences between men and women when first confronted with the differing genitals of men and women. Instead, the understanding appears to come from social cues which children begin to increasingly understand. Also, when studying children and their parents, children are not exact replicas of their same-sex parent which would indicate that it could not be entirely identification with the same-sex parent that drives the development of gender-appropriate behavior and attitudes, beliefs, and ideas about gender (Brooks-Gunn & Matthews, 1979, p. 105). His theories have been
proven to have flaws, but cannot be discarded entirely as they continue to offer some insight into gender development.

The identification theory of Freud may fall short of accurately describing gender development, but many other theorists have developed identification theories that have proven useful. Karen Horney, a generation younger than Freud but also considered a Freudian, focused on an area which interested Freud little and was thus greatly ignored: women. She presented the idea that rather than women being envious of men’s genitals, it was men who were envious of a woman’s capability of carrying and giving birth to children. Because of this, men choose to hold women to be inferior because they are trying to deal with their own feelings of inferiority stemming from their inability to give life. She also pointed out one of the failings of Freud noted before, that it is social differences rather than biological that influence gender development (Brannon, 2002, p. 108-109). Less focused on biology, the dynamics of inferiority are scrutinized to reveal an alternative view of the motivation for advocating the inferior status of women.

Robert Sears developed one of the first of these in the 1960s. He believed that identification rather than being based on fear in the child, is a positive and supportive phenomenon. Identification instead of being driven by fearfulness in the child is the product of love and learning. Rooted in love for the mother, the child identifies with her to maintain a sense of her qualities when she is not there. Because mothers are most often the caregivers for young children, they become associated with pleasure and gratification to the child due to the nature of the care that they give. In their care giving role, mothers are often the providers of
food and love and other such positive necessities. The desire exists for those when the parent is absent. Sears holds that boys eventually change from identifying with the mother to identifying with the father because of a desire to be an object of love rather than a provider of it (Brooks-Gunn & Matthews, 1979, p. 107).

More recently, Nancy Chodorow also extended the psychoanalytic theory of Freud and developed her own way of considering gender development. She incorporated feminist theory into the work of Freud, and looking at his work through a this lens shaped her own theory. Her emphasis was on early infancy, where she believes gender development is rooted (Coltrane, 1998, p.118). This is highly interesting considering that most theorists of gender development, including those outside psychoanalytic theory focus on the preschool years as the beginning of gender development (Brannon, 2002, p. 114-116). Chodorow theorizes that girl children are allowed to stay close and affectionate with mothers longer than boys. This prolonged affection allows girls to remain more connected with the world around them. Boys, on the other hand, become more detached and independent because they have severed the close bonding earlier on than their female counterparts. In separating themselves from women, unfortunately, Chodorow believes that boys devalue their mothers as a justification for rejecting femininity. Chodorow uses this theory as an explanation for how mothering is reproduced from generation to generation (Coltrane, 1998, p. 119).

Social Learning Theory
Growing out of traditional behaviorism, social learning theory emerged in the 1960s as an alternative to identification theory in explaining gender development. B.F. Skinner's behaviorism emphasizes conditioning as the means of determining how to negotiate situations. Rather than conditioning, social learning theory focuses on the fact that observed reinforcement of behavior can communicate gender appropriate behavior. According to social learning theorists, reinforcement can come from a variety of sources, including those that are not directly enacted upon the child. By learning from observation, social learning theory holds that there is thought involved in behavior while behaviorism holds that is simply automatic reaction. Children observing the reinforcement of others can still function as reinforcement for that child. Social learning theory focuses on external as opposed to internal factors in influencing gender development (Brooks-Gunn & Matthews, 1979). Specifically, social learning theory examines the social context in which children acquire gender.

The key concepts for social learning theory are reinforcement, observation and imitation. Reinforcement is any action that will increase the probability that the reinforced behavior will occur again (Brooks-Gunn & Matthews, 1979, p. 109-110). By observing, children can see the actions of other people and determine what reinforcement and punishment the other person receives. In future situations, the child will be more likely to repeat observed behavior if it has been reinforced and less likely to repeat it if they have observed punishment for the behavior. Observation serves as a sort of reinforcement lesson in what the consequences of various actions will be without taking the risk themselves. After
observation, children can decide whether they can or cannot do something according to the rules of society. Imitation is when children practice these behaviors that they have seen and then adopt them as their own behavior (Brooks-Gunn & Matthews, 1979, p. 112). Children who see another child praised for something are likely to imitate the act to try to receive the same sort of feedback.

Social learning theory holds that these principles can be applied to many behaviors, but of concern to this discussion is obviously the ways in which they apply to messages about gender. Reinforcement for boys and girls for the same task can be different, socializing them quite differently. For example, a boy and a girl can play with a doll, but the adult reaction to it is often different for the sexes, reinforcing differently. Boys receive negative feedback while girls receive positive. Children can experience this, see what happens to another child, see it on television or by another means and understand what they are or are not supposed to do. It is because of the impact of society’s reactions that the power to develop the idea of gender lies with that society and how it reacts to the behavior of children.

**Cognitive Developmental Theory**

Another school of thought labeled cognitive developmental theory also believes that children gain information about behavior from the world around them, goes further than social learning theory in its beliefs about what determines behavior. This theory states that construction of gender is actively performed by the child internally rather than motivated by the external action of
reinforcement. It is through children’s attempts to understand the world that they develop an understanding of gender, and their actions are therefore determined by thought alone. At the foundation of cognitive developmental theory is the work of Jean Piaget who emphasizes maturation, experience, social transmission and equilibration (Brooks-Gunn & Matthews, 1979, p. 116). Central to Piaget’s work is the idea that children develop in stages, acquiring new skills and capabilities on a relatively rigid schedule.

According to this theory, children are constantly trying to understand the world around them so they organize it into more comprehensible categories. In the case of gender, children begin to use it as an organizing principle so that the world around them can be more easily deciphered. Boys behave one way, girls another. With this type of thinking the world becomes ordered as opposed to chaotic, a more tolerable state. What emerges is a world divided into distinct categories according to gender. There are, of course, individuals and behaviors that will run counter to these categories. When children encounter these examples, it turns their categories upside down. Prior to this, their categorization can be described as being in a state of equilibrium. When new information is introduced, the categories must be modified to accommodate the new information and reestablish equilibrium (Brooks-Gunn & Matthews, 1979, p. 116). In this way, as children grow older and face more examples of individuals of both genders performing non-stereotypical actions, their views of gender become more complex as they accommodate, assimilate and equilibrate.

Gender remains a socially driven concept, however, because the information that is taken in and equilibrated is taken from the experiences that
individuals have with the world around them. In our society, the categories of
male and female have roles that are socially dictated and are thus artificial in
many ways. These roles are perpetuated when children use them to construct
their knowledge of the world around them. Children who see that only their
sisters have to do the laundry like their mothers and only brothers have to mow
the lawn like their fathers are likely to assume that the organization of these tasks
is because of gender. This organization goes on taking in examples from in the
home, at school, on television, essentially whatever children are exposed to they
take in and try to understand.

Lawrence Kohlberg’s theory of gender was in some ways a combination of
social learning and identification theory. He believed that gender development
took place in a series of three steps beginning with the child dividing the world
into two categories based on gender. The next step was that children then attach
a value to the people, attitudes and behaviors of one category (one gender). He
also believed that children identify with the same-sex parent, as do the
identification theorists (Brooks-Gunn& Matthews, 1979, p. 118).

As developmental theory evolved, more critique and integration of
theories took place. Sandra Bem notably developed Gender-Schema Theory
which is a blend of cognitive developmental ideas and social learning theory.
“Gender schema theory proposes that, in addition to learning such content-
specific information about gender, the child also learns to invoke this
heterogeneous network of sex-related associations in order to evaluate and
assimilate new information” (Bem, 1983, p. 572). While very similar to social
learning theory, using schema is actually a different way of arranging information
in the mind (Coltrane, 1998, p. 121). A schema is a more unified way of thinking about a concept as opposed to being just one of many ways of organizing. The schema includes all values, attitudes, and beliefs that are incorporated by the child into one construct.

An extension of this theory is gender script theory in which children organize ideas of gender according to social scripts. A social script is a sort of preordained progression of events that we learn and carry out over and over again when particular events arise. For example we have scripts for events like weddings; there is no one announcing that you must stand when the bride walks down the aisle, but everyone knows that it is what is expected and does so without question. A gender script is thus similar to schema in that it is a collection of ideas about gender, but it has the added restriction of being sequential in nature (Brannon, 2002, p. 138). The reactions of individuals to one another are based on their gender. A man is to open a door for a woman, etc. We know what will come next, what to do next, because we have been socialized to follow these scripts.

While these theories are different in many ways, it is important to note how the family can be very important in each. Through identification, observing or receiving reinforcement and punishment from parents, and providing a learning environment the family plays an integral role in all of these theories. As discussed, while none of these theories are considered more accurate than another, understanding the role of family in each is important in terms of understanding how important the family is in developing gender roles.
Chapter 3

Gender and Family: Parents as primary socialization agents

The previous chapter outlined ways in which a child comes to understand gender and theories about the mechanisms children use to acquire gender roles. Each theory requires that children observe the world around them, its people and things, to gather information to decipher social codes in which they are expected to become fluent. A children’s environments are diverse, and there are countless opportunities for learning about gender and therefore many factors that affect how a children come to see gender.

It is generally agreed upon, though, that the most important agent of socialization agent of all, at least in the case of gender, is the family. The family is in a unique position because it provides and controls nearly all early experiences, environments and interactions in the early years of a child’s life. Even when not present, parents make choices about who cares for their children, what school their children attend, and many other important choices. While theories differ over how children learn about gender, they all share the characteristic that the process happens in a social context. The family is the primary provider of this context.

The earliest theories of gender were those that examined identification as a means for acquiring gender; they relied more heavily than some the later theories on the role of the family, more specifically the parents, in the process. It is only with identification with one parent or the other that children are able to
develop a sense of their own gender, so the family is clearly the primary socializing agent in terms of gender. There is little or no mention of people outside the family that as individuals that a child could possibly identify with, suggesting that it is entirely the family influences the acquisition of gender roles. By either identifying or rejecting a parent, children begin to develop a sense of what their gender means.

Social learning theories that emerged after identification theory also have aspects that rely heavily on the family, especially parents, as agents of socialization. As described in the previous discussion of social learning theory, learning by observation is the key to a child’s acquisition of gender. “The way in which parents reward different kinds of behaviour in girls and boys is a prominent feature of the social learning explanation of how children develop traditional sex roles” (Statham, 1986, pp. 103). In the early years of life, the family is one of the few places that children receive any reinforcement. Parents reinforce in many ways, by the objects they provide children, and by the ways they speak with them. Either reinforcement or punishment, tells the child which of their behaviors are appropriate or inappropriate.

Because of the roles that parents are said by social learning theory to play in the reinforcement process, recent research has begun to look at these reinforcing behaviors. They have found that parents do in fact reinforce gender roles, whether deliberately or not. Often inadvertently, parents treat their children differently depending on the gender of the child and those responses serve as reinforcement of, most often, traditional gender roles that are engrained in the parents’ way of living and thinking. The reinforcement is not always an
explicitly stated desire for the child’s future action based on the current actions which are in or out of sync with expected gender roles, but subtlety does not detract from the power of the messages that parents are sending.

The impact that families have on the ways that their children come to understand gender is not in any way limited only to positive or negative reinforcement or punishment of behaviors along gender lines or identification. Cognitive developmental theory advises us that children use gender as a way to organize their world so that it is easier to understand. Families play a key role in influencing this organization because they create the worlds in which the children are constructing their understanding of life. Families provide an environment that is extremely important for learning about social situations. Everyday social situations are reproduced within the context of the family. This reproduction is the conscious and unconscious messages that are being sent by the parents as well as the situations that they create.

**Rituals and Everyday Social Interactions**

As previously indicated, the environment that the family creates can be a risk factor for eating disorders. As gender is shown to be a risk, the environments created by family sets up the world in which children learn gender. Because of the nature of the parent-child relationship, it is the parents who often dictate the media present in the home, the activities that take place within it, as well as a myriad of other details that form the basis for an impression of the world. The family thus serves as a microcosm of society and the place where children learn
their own gender lessons - lessons they then apply to the world (Coltrane, 1998, p. 112). If they see that their mother along with an older sister does the cleaning while a father and brother do not, it would be natural to assume that only females clean. It is exactly this sort of assumptions that children use to organize their world.

In *Gender and Families*, Scott Coltrane uses the example of the family ritual as an activity in which children acquire many of their ideas about gender. Family rituals, whether it be a Thanksgiving meal or watching television together, provide repeated experiences for children that generally follow a similar script each time they are repeated. The frequency and repetitiveness of the ritual make it easier for children to ascertain gender patterns. They notice who says grace or holds the remote control, and, consciously or unconsciously, these rituals become lessons in gender (Coltrane, 1998, p. 19). Scripts and schemas are founded on these types of situations and help the young mind organize incoming information.

Often, rituals are used to mark or celebrate transitions from one part of life to another. Common examples are weddings, engagement parties, baby showers, and bachelor parties. These rituals often become exaggerations of society’s prescribed roles and emphasize the importance of crossing from one role into another (Coltrane, 1998, p. 20). Baby showers, for example, are often ladies only and bachelor parties encourage men to “go wild.” Traditional wedding vows are not even the same for men and women. The jobs that each gender are given or choose to take on in organization of the rituals that reveal a family’s feelings about gender as well (Coltrane, 1998, p. 20).
of each gender into neat categories is made easier for young boys and girls by these exaggerated situations. The previous assumptions become reinforced or corrected by the extreme gender segregation seen at rituals. There is overwhelming evidence being presented to them that gender stereotypes do in fact indicate how one should behave.

Of particular importance to the discussion of eating disorders, these rituals also serve to teach children about what their relationship with food should be. In particular, girls tend to learn eating habits from their mothers (Davis, 2001, p. 97). This results in the transmission of gendered relationships with food from generation to generation. This is more of an issue for girls than boys because of the different ways in which they are taught to deal with things. Boys are taught to “be tough and generally show anger or frustration through physical expression, whereas girls are taught to show more emotional expression. Food can become their comforter and emotional outlet” (Davis, 2001, p. 97). The environment created by the family can increase the probability of turning to food because they learn that this is in fact appropriate for women to choose food as an outlet.

All of these different situations create the environment in which children are growing up and learning about the world. It is these situations that children are using to organize characteristics into categories of masculine and feminine. The family not only creates the environment in which children live their daily lives, but the family also dictates which situations children are exposed to on special occasions.

**Gendered Environments**
In an ideal world, regardless of the gender roles that they have accepted, parents would treat their children with equality. Parents, however, have gender stereotypes that are very ingrained in their perceptions and actions and this often spills over into their parenting. Unfortunately, this behavior is often unconscious so that transmission of stereotypical gender roles from one generation to the next can be unintentional.

Traditional gender roles are never questioned by most parents, that even their perception of their children is clouded and skewed by their gender expectations. The classic and oft-repeated study that shows this tendency is the “Baby X” experiment. A baby is dressed in a fashion that is stereotypical for one gender or the other. The dress may or may not correspond to the actual sex of the baby. The subjects who are other parents are asked to describe the unique characteristics of the baby. Then the child is dressed as the opposite gender, and again adults are asked to describe the child. While the infant is actually the same in both cases, when the adults believe that the infant is a girl they describe it as littler and softer than when the adults thought that it was a boy (Coltrane, 1998, p. 124). The adult knowledge of the sex of the child overrides their physical perception of the child since obviously the actual characteristics of the child did not change. Such attributions can influence the way parents interpret the needs and personality of their baby.

Even parents who consciously want to raise their children in a non-sexist manner often transmit traditional values unconsciously. This has been shown in various different studies in which parents were asked to respond to children labeled with a sex that was randomly assigned (Statham, 1986). As noted above,
the perception of the children in experiments like “Baby X” is heavily influenced by the expectations of adults, most frequently their parents. The inability of parents who want to raise their children in a non-sexist manner to resist gender stereotypes shows the extent to which this is attribution process is unconscious.

In other similar studies, parents were also deficient in their ability to label the emotions of infants and seemed to rely on gender cues in making decisions about what a child was feeling. When shown a video of a child that was crying, parents responded with different causes for the tears depending on what they were told the sex of the child was. While the video was actually the same in all cases, when told that the baby was a boy, the parents attributed the crying to anger, but attribute it to fear in girls (Statham, 1986, p. 31). In misattribution of emotion, parents are creating a personality for the child in their minds based on stereotypes that cause them to believe their child actually possesses the stereotypical traits. These conclusions lead them to believe that their child making stereotypical choices in toys, games, etc., when it is the parents who have reinforced traits and emotions in the child. Children will pick up on the fact that a parent will treat them as either angry or fearful when they cry so that when those emotions truly emerge, they understand that crying is how they will receive the proper attention to their needs.

If differences stopped at what characteristics the parents perceive in the child, the effect on the child might not be great, but they do not stop there. There are profound differences in the way that adults interact with children depending upon their gender. As the individuals who have the most contact and control most other contact with the children, this differential treatment by parents has a
huge effect on how children grow to view the world and how their gender fits into that world. Children use play as a way to learn about the world around them, and it is in fact an enormous factor in their learning (Hamner & Turner, 2001, p. 61). In general, adults give girls more verbalization, interpersonal stimulation, and nurturance play. Boys, on the other hand, receive more whole-body stimulation and encouragement of activity (Coltrane, 1998; Statham, 1986). Regular participation in these kinds of play help girls become proficient in interpersonal skills and caring activities while boys develop mastery of motor skills and manipulative activities.

The type of interaction a parent has with a child is critical because of the needs of the child for that interaction. If parents involve themselves in one type or subset of activities almost exclusively, it will communicate considerable information to that child. It conveys to them that these are activities are approved by their parents, and the children are likely to seek this approval. Since interaction in and of itself can serve as reinforcement, they will learn that this is a way to get attention from their parents in a manner that is positive.

One of the most obvious areas where this happens is when parents play with the child. Male and female parents choose very different activities for boys or girls. A study by Lindsey and Mize looked at the types of play that were prevalent between parents and children and found that with girls, parents engaged in more “pretense play” or pretend play than they did with boys. This type of play was also more common in mother-daughter pairs than father-daughter pairs. Parents engaged in more physical play with sons, and similar to the mother-daughter findings, more dads engaged their sons in this manner than
moms (Lindsey & Mize, 2001). This reinforces physicality in boys and interpersonal relationships in girls. Both parents reinforced the stereotypical play in both sexes, but it also took the socialization a step further. Children observed their parents more often engaging in play that is considered appropriate for the parents’ gender and learn what is appropriate for genders accordingly.

These researchers then looked at the way these children played with peers and found that children often played the same types of games with their friends as they did with their parents. Quite significantly, they were more likely to play the “sex-appropriate” type of play if their parents had engaged them in it (Lindsey & Mize, 2001). This is quite significant because it can then lead to gender-segregated peer interaction based on activity choice that will perpetuate the sex-segregated learning process. Their activities will be limited to sex-appropriate activities which in turn reduces their chance for reinforcement in other areas.

Another group of researchers looked not only at the type of play that parents engaged in with their children, but the toys that they chose for play when interacting with their children. The researchers had three categories of toys - traditionally masculine, traditionally feminine, and neutral. The parents were first asked to classify the toys as masculine, feminine, or neutral themselves. An interesting trend appeared where the parents classified more toys as neutral than did the researchers, the neutral group expanding while both masculine and feminine groups decreased in size. For example, a ball was classified as masculine by the researchers and a telephone as feminine, but the parents ranked
both as neutral. While the parents reported a broader sense of what toys were neutral, this did not affect the toys they chose when they were playing with the children. The parents still chose sex-appropriate toys the most for their kids. There was somewhat more flexibility with the toys chosen for females, but overall the parents chose toys along gender lines (Wood, Desmarais, & Saragugula, 2002). Toy choice limits the type of play that children will engage in, so choosing more sex-appropriate toys will in some ways limit them to more sex-appropriate play, again limiting the chance to receive positive reinforcement for non-traditional activities. It is encouraging to supporters of egalitarian parenting to see that parents ranked toys as neutral, but it does little in terms of socializing a child if the parents still choose the sex-typed toys for their children. Again, for children, play is a very important way to gain social skills and learn about the world around them (Hamner & Turner, 2001, p. 61).

Toys are central to a child’s activities and are among their only possessions. Children may express a desire for specific items, but with no income, it remains up to the parents’ discretion which toys a child will receive. The parents in the Wood, Desmarais, and Saragugula study chose toys they believed the children would want to play with, so it is likely that they would buy the same toys for their children. Parental control over play could then override the desires of the child, and from the above examples, it is likely that the parent will choose toys that are considered sex-appropriate more than ones that are considered appropriate for the opposite sex or even toys that are considered gender-neutral.
This differential treatment of boys and girls also shows up in the stories that their parents choose to tell them. In general, boys are more likely to hear stories about autonomy than are girls, and fathers are more likely to tell the stories to them. Interestingly, though, in families that are traditional in terms of gender roles, boys are more likely to hear stories about achievement than are girls, but in non-traditional families the opposite is true (Fiese & Skillman, 2000). The stories transmit morals by showing the consequences of different kinds of behavior. This can serve as indirect reinforcement because the children hear from their parents that the behaviors of the children in the stories are rewarded for their actions. The story serves as an example to children of how to act because not only is the character in the story rewarded for acting as they were, but their parent chose the story which means they approve of its message.

As demonstrated by the above study, parents pick and choose the stories they tell their children, and they are thereby picking and choosing the morals (reinforcements) that they choose to demonstrate to their children. Parents are more aware of how they verbally convey messages than how they transmit them through action. Much of the information that children receive about the world is filtered through their parents first, and parents make deliberate decisions, conscious or unconscious, about what lessons they want their children to learn through verbal messages.

Parents verbally transmit their feelings about gender in many ways besides choosing stories that relay the messages parents decide they would like their children to hear. Differential treatment has been observed in the speech patterns of parents with their daughters and sons in ways that place more value on the
words of the male children than female. Daughters are interrupted twice as often as sons by their parents. This provides the daughters and sons with an indication as to their relative power and importance as well as the worth of their opinions in the eyes of their parents (Statham, 1986, p. 30). Whether consciously aware or not, parents show that they are more interested in what their sons have to say than their daughters. In terms of reinforcement, girls receive punishment for their participation in conversation while boys receive positive reinforcement for it.

Indirect, or even inadvertent, messages actually appear to be quite common methods of transmitting gender roles from one generation to the next. Beverly Fagot, who has done much research in the area of parents transmitting gender roles, has found many different ways in which parents treat sons and daughters differently. She has noted that boys are left alone more often and for longer periods of time than are girls (Statham, 1986). The parents in the study were not trying to transmit the idea that boys should receive more independence, but they unintentionally are doing so by allowing the boys to have it. Boys are able to build confidence in their ability to function without assistance, while girls are not given this chance. Even when both son and daughter received positive reinforcement after completing a task, the son would know that he accomplished this completely on his own, while a daughter received the communication that the parent did not have faith that she could do the same.

The reinforcement in the study was not explicit, but as far as direct positive reinforcement is concerned, Fagot also studied the responses of parents to various specific behaviors that their sons and daughters exhibit. Again
regarding the ability to complete tasks successfully, parents respond more positively to girls than boys when they ask for help with things (Statham, 1986, p. 31). This reinforces in girls the idea that they need assistance to be successful and are in fact dependent upon others. Parents also respond in a more positive manner to boys when they partake in play that involves manipulating objects, clearly reinforcement of the traditional male role (Statham, 1986). Like the above situations where parents were more likely to engage in that sort of play with their sons, encouraging them to do it alone as well tells them that active pursuits are desirable for boys.

While far from reflecting the full extent of the research that has been done on the differential treatment of boys and girls, the above examples are an excellent indicator of trends in parenting. Limited so far to discussion of reinforcement, the picture is beginning to shape up that the family in its role as primary socialization agent of children tends to reinforce traditional gender roles.

Notably, from delivery to toddlerhood, male and female infants are much more similar than they are different, and it is the parents who impose gender upon their children. They choose to dress them in clothes that reflect their gender and place them in rooms that are decorated in ways that are considered socially appropriate for that gender. This can be seen quite often with pink clothing and bedding for girls and blue for boys (Coltrane, 1998, p. 126). While a baby is not conscious of the connotations of the colors during infancy, the choice by the parents shows their engrained assumptions about the personalities of their children. They will begin to understand as they age though, that girls’ rooms are pink and boys are blue because they will see this pattern most frequently. Colors
of a baby’s room are not the only patterns that children will begin to become discernable. Toys and other objects that are in the room begin to show a correlation with sex, and so on, until a schema is clear and defined.

As the previous paragraph begins to demonstrate, assumptions can build upon one another so that the stereotyping increases as children get older. In preschool and kindergarten, parents continue to provide gender-stereotyped toys and furnishings maintaining an environment of gender stereotypes (Coltrane, 1998, p. 126). The gender-stereotyped surroundings are thus accumulating, increasing the accessibility of stereotyped experiences for the child to draw upon while learning.

**Non-traditional views**

Children absorb information about gender from their parents in ways other than through direct interaction and environment. Parents transmit ideas about gender through actions that do not in any way involve their children in addition to the ways discussed above. For example, maternal employment is associated with less traditional attitudes and beliefs about sex roles in children. One explanation for the observation of this pattern is that mothers enjoy increased stature and power in the home because of their dual roles. There is also a greater overlap of roles inside and outside the home that children observe because more often in these families, both parents take care of the home and both also act as providers (Statham, 1986). By having both parents participate in similar activities and enjoy more equal amounts of power, these traits do not get filed into one category or another during the organization of gender roles. The
availability of examples of women in “men’s roles” and men in “women’s roles” helps children to hesitate in stereotyping activities, resulting in less traditional beliefs.

Another interesting consequence of having a working mother is the beneficial effects of having a mother who is not totally involved in home and children (Statham, 1986). These beneficial effects could lead to children being able to develop more non-traditional gender attitudes. Working mothers also serve as more liberating role models: more girls say they want to be like their mothers if they work than if they are stay-at-home moms (Brooks-Gunn & Matthews, 1979, p. 156). The working mother is part of an environment that communicates to girls that they are capable, independent people. The larger number of girls with working mothers who want to be like their mothers shows the positive effects of having available examples of strong women in the environment of those girls.

Many of the above instances demonstrated how children adopt their parents’ stereotypical gender attitudes, attitudes that also happen to be those of wider society as well. Adopting traditional views from parents that are the most prevalent in society from parents seems little proof that it is the parents that are the primary socialization agents. In a study by Risman, however, sixteen of twenty-two children who were raised in egalitarian families were shown to have entirely adopted their parents’ views (Risman, 1998). This is a very important finding because it gives validity to the original claim that parents are the main agents of gender socialization for young children. As depicted previously, children pick up traditional views with considerable ease, but this showing how
non-traditional views are acquired in the same manner definitively argues that it is in fact the parents who are socializing their children in a most significant way. The children in the study did not adopt views that they may have picked up elsewhere, but instead learned from their parents.

Egalitarian child-rearing is not without its challenges, however. After the children raised in these homes go to school, they are faced with a very different reality from the one that they have at home. Their first-hand experience overrides their principal values system. This manifests itself quite interestingly since the children do not themselves reject their parents’ ideas completely; instead, they seem them as applying solely to adults (Risman, 1998). The children had more stereotypical beliefs about boys and girls versus men and women. The children in the study were more aware, though, of the stereotypes since it seems to be a step in a more progressive direction.

It is also quite important to note that the children were all well adjusted, showing that non-sexist child rearing does not harm the development of children in anyway and that rigid, stereotypical gender roles are not a necessary part of rearing healthy children (Risman, 1998).

The fact that children’s abstract views are challenged when contrary examples are observed is a strong argument for cognitive developmental approaches to gender development. While holding the belief that men and women are equals, the children in the study were forced to assimilate and accommodate the incompatible experiences that they had at school. On a positive note, however, the children were able to do so without totally scrapping the views that their parents have so purposefully tried to instill in them, and were
instead able to modify them so that they were able to stay true to the values that they learned in some capacity.

The above situations have all been examples of studies in which the researchers have been trying to study parents unwittingly transmitting traditional sex roles. Because parents are self-conscious about being parents and the quality of their parenting skills, researchers are unlikely to gather any accurate information by self-reporting methods. A weakness of this form of study is that it requires considerable assumption on the part of the researcher as to the intent of the parent or the meaning of their actions in terms of transmitting gender roles.

It may seem that if children are well-adjusted when they are raised by traditional parents or parents that are non-traditional in their beliefs about gender, that discussions of mental illness need not address the manner in which parents choose to actively teach their children about gender. This is partially since kids may be well-adjusted with either practice, but there has been some evidence to suggest that teaching kids non-traditional ideals could have a positive effect on their ability to deal with stress.

In a study of the influences of gender and race on adolescent adjustment, DuBois et al. found that having a positive gender identity enabled adolescents to better deal with the stress with which they were faced on a daily basis. In their model of teenage stress, positive gender identity served as a mediating factor for stress. Negative gender images and attitudes were things that brought stress into lives of adolescent girls. Those with positive views about their gender were better able to see the stereotypical images for what they are and not let them bother
them (DuBois et al., 2002). Creating positive gender identity is thus something that parents should think about when raising their children because it could help equip their children with skills for dealing with stress in a world that bombards them with negative images.

Clearly family influence cannot be ignored when looking at how children view gender is clear. The family provides the social framework for children to learn about gender. As the architects of this framework, parents have considerable influence over its design and ultimately its function. That gender is so tightly linked with eating disorders naturally draws the family into a discussion of them. In the following chapter, it will become clear that it is not only the gender of the individual, but the character of their views that are linked to the stresses associated with eating disorders.
Chapter 4

Families and Eating Disorders: Family environment as risk factor

The previous chapters have shown how the family creates an environment in which their views about gender can pose as a risk factor. There are many more other family factors that can compose risk for eating disorders. Some frequently identified risks include problems in family functioning, discourse about weight, and mediating the effects of the media.

As noted before, those with individuals with eating disorders in their families are much more likely than those without to develop eating disorders themselves. There is also a pattern of more affective disorders in general (Killian, 1994). Whether this is a genetic predisposition or a problem stemming from family functioning problems is yet to be determined, but it is important to note the tendency. Gender role stress has been cited as a cause of both depression and eating disorders and could be tied up in family factors.

There are a few characteristics that many families of individuals with eating disorders seem to share. The families of individuals with eating disorders come in general from upper socioeconomic classes. Running somewhat contrary to intuition, children with eating disorders are less likely to have parents that are divorced than those who do not (Clopton, Haas, & Kent, 2001, p. 167). This will be extremely important later when the discussion turns to the maintenance of the family system as a possible risk factor. There are more members to maintain in intact nuclear families. These factors give an idea of the demographic to which
girls with eating disorders belong. Eating disordered individuals themselves are also most likely to either first or last born and more often have sisters rather than brothers (Clopton, Haas, & Kent, 2001, p. 167).

Families of children with eating disorders seem to have a common set of values as well. They emphasize “achievement, success, conformity and traditional concepts of femininity, and appearance” (Kog & Vandereycken, 1989, p. 11). As we have noted previously, good gender feelings are correlated with heightened functioning for teens and traditional ideas of femininity put stress on the individual. It is therefore not entirely surprising that both trends were noted by Kog and Vandereycken.

In looking at the possibility of differences in the families of individuals with different eating disorders, it does not seem that the family functioning is different between the different types of disorders. A study of anorexia and bulimic patients examined the functioning of their families and found that there were no significant differences between them (Latzer, Hochdorf, Bachar & Canetti, 2002). There are several suggestions as to why this would be the case. While the manifestations are different in the diseases, it appears that they stem from the same underlying cause. This can be observed in the way that bulimic and anorexic patients often exhibit symptoms of the other disease, sometimes shifting from being more of one to being more of the other (Latzer, Hochdorf, Bachar & Canetti, 2002). This finding is quite important because some populations studied are mainly one type of disorder or another, and it is notable that in terms of family functioning, findings are at least somewhat generalizable
to all eating disorders suggesting the disorders stem from the same underlying familial problems.

There are also several traits of family dynamics that are common among families with children who have eating disorders. Minuchin described five such traits: enmeshment, over-protectiveness, rigidity, lack of conflict resolution, and involvement of the child in conflicts between parents (Clopton, Haas, & Kent, 2001, p. 166). Enmeshment is an over-involvement of family members in one another’s lives. It restricts independence and privacy of the members of the family from one another. Rigidity can be described as “an extreme emphasis on maintaining the status quo” (Clopton, Haas, & Kent, 2001, p. 166). Rigidity often manifests itself in a resistance to change that can be extremely unhealthy during times when change is necessary and natural. Upon identifying these characteristics, they have been worked into many forms of treatment for eating disorders increasing effectiveness (Clopton, Haas, & Kent, 2001, p. 172). Rigidity here is of particular interest because the status quo is not necessarily a good thing to maintain in terms of tender. Adolescence is a period with extreme change so rigidity can cause considerable tension in the family which can lead to stress.

Many blame media and culture for the development of eating disorder, stressing the pressure by the media that is put on girls to be thin. There is evidence though, that the family can play an important role in mediating the effects of culture (Haworth-Hoeppner, 2000). The family can either help children to deal with the pressures from media and culture or place even more pressure on them by valuing or emphasizing them. It appears that the above family dynamics described above set up exactly the type of environment that
amplifies cultural pressures (Haworth-Hoeppner, 2000). This finding is significant because it may signal some of the ways that the above observed characteristics function in the development of eating disorders.

There are family factors that can also contribute to the development of a poor body image, a risk factor for and characteristic of eating disorders. One way that this occurs is through the internalization of negative feelings from parents. As social learning theory proposes, children get feedback from their parents about the world. If that feedback includes that girls must be skinny or that they are somehow not attractive enough, the results can be devastating. Girls can also see their mothers struggle with their weight, obsess over it, complain about it, all the while dieting and exercising to try to become content. Through a process of identification, these girls come to see this as normal and find their own bodies to be inadequate as well (Kearney-Cooke, 2002). Furthermore, parents who believe that they themselves are overweight are more likely to be concerned about their child’s weight and try and help them to stay at an “ideal” weight (Striegel-Moore & Cachelin, 1999, p. 97). This emphasis on weight creates an environment in which weight can take on unnatural importance.

Evidence of this type of situation has been found in families that discuss weight and adhere to the norms of the greater culture, with thinness as the ultimate goal. Even in families that are otherwise loving, if weight is discussed as being important with an emphasis on thinness, there is a higher correlation with eating disorders than in those families that do not discuss eating disorders (Haworth-Hoeppner, 2000). “Within the family, a main discourse on weight operates as a ‘defining’ mechanism for development of collective identity...it
creates a common outlook about the inherent value of being thin” (Haworth-Hoeppner, 2000, p. 223). This common outlook, while serving to hold the family system together, can be destructive to individuals who are susceptible to the development of an eating disorder.

Cultural ideals are thus mediated by the family in the presence or absence of a discourse on weight and the content of the discourse. This deeply affects the development of body image (Haworth-Hoeppner, 2000). The idea that the family is integral in the development of body image is extremely important when trying to examine the relationship between family and eating disorders. Eating disorders are so defined by the presence of distorted body image that the suggestion of family involvement has tremendous implications for prevention and treatment in the future.

While it is true that general family functioning problems are found in the families of those with eating disorders, but it appears that specific family climate variables have an even more significant correlation. In a study of both, the specific variables like a family placing considerable emphasis on appearance are more important factors in developing an eating disorder. In families with generally poor family functioning, the result could likely be depression rather than an eating disorder (Laliberte, Boland, & Leichner, 1999). It is important to note that this study represents data collected from the eating disordered individual themselves and their family members. The results could represent a perceived pressure by eating disordered individuals rather than actual pressure from the family. Family responses were similar to those of patients, however, suggesting that the perception is not skewed (Laliberte, Boland, & Leichner,
Further research will need to explore the topic more, but the current evidence suggests that families that emphasize appearance and achievement are a risk factor for some individuals.

The family is quite obviously a huge consideration when examining eating disorders. While creating a set of ideas about gender, the family is also responsible for creating an environment in which stresses can be alleviated. Unfortunately, the family is also then responsible for creating environments where this stress cannot be dealt with in a healthy way and in which eating disorders flourish. The building stress in these situations could be in part due to the make-up of the family system. The next chapter addresses what it is about families that enables them to be safe havens or unhealthy. The dynamics between the individuals of a family are in large part responsible for the creation of this environment and are therefore the next area of interest.
Chapter 5

Family Systems:
Family function as risk factor for eating disorders

Choosing a Model

To describe the family and better understand the way that the various factors function, it is necessary to choose a model that will be most useful. There is justification for the use of this family systems theory because older models of family functioning have proved to be ineffective in describing interactions between and among members. This has been especially true when trying to learn about the origins of psychopathology. Trying to use causal models does not accurately portray the path of mental illness and inherently ignores many aspects of the diseases. In trying to treat and prevent disease, the causal model is misleading which can only serve to exacerbate the problem at hand.

Causal models cannot address any situations that do not consist of one event influencing the outcome of another. For example, coercive cycles where there is continual feedback causes a problem to grow in magnitude over time cannot be identified by a causal model or research. A problem that escalates over time is a way that the response of one individual to the other causes the response in that individual to be amplified cannot be properly examined with a causal model in mind (Cowan, Cowan, & Shultz, 1996, p. 4).

Various problems that an individual may encounter are many times not mutually exclusive, putting kinks in a causal model. A causal model does not allow for the overlap of illnesses because of the nature of the categorization of
symptoms accompanying diagnosis (Cowan, Cowan, & Shultz, 1996, p. 5). A person who has bulimia and anorexia may also suffer from depression or other mental illnesses, but they also may not and there is little accounting for the difference in whether there is only one illness present or many.

Causal models inaccurately describe the etiology of psychopathology because of the way that a correlation is determined and interpreted. A correlation between two events discovered in research is often taken as one event causing the other. The first event may or may not cause the second event, but because of the nature of studying mental illness with controls, those events are isolated and may not take into consideration a third event. So when considering the mental illness that research has found to be correlated to a certain event it is impossible to draw the line backwards from illness to determined cause because there could be a third circumstance influencing the situation (Cowan, Cowan, & Shultz, 1996, p. 5).

To examine the family and the power it has to shape its members and their mental health, the complexity of the family can in many ways seem overwhelming. The variables seem infinite and the possibility of examining each of them separately would be impossible. Analyzing the family as a system, however, provides many useful insights into the dynamics of the family and its complicated interactions.

**Describing the Family System**

It is necessary to clarify what a system is before jumping into an analysis of a family as one. A system is a “collection of interrelated components and the
existing relationship among components” (Montgomery & Fewer, 1988, p. 94).
When this definition is taken for exactly what it is, the entire universe is one system. It is not efficient or useful to examine the entire universe to examine relationships between a few relatively small components. Within the larger system, components are arranged into subsystems, and it is in these that the interest lies for examining families. The family is a subsystem of the larger system and in turn has subsystems of its own, but it is important to place it in the context of a larger system (Montgomery & Fewer, 1988, p. 96).

Another important concept to articulate when considering systems is that of continuous interaction. The components of a system, in this case, the family, cannot be separated from one another because they are constantly affecting and being affected by one another (Montgomery & Fewer, 1988, p. 97). The greater connection of all things and the inability to separate them fully into individual parts serve as the basis with which an examination of family systems rests.

In defining the system of interest, the family, it is important to examine when that entity can be considered a system. As described above, a system is dynamic and therefore is impermanent. Integration is the term used to describe a system’s unity, and a system is intact as long as it is integrated. The opposite of this would obviously be disintegration, which occurs when the ties that hold the system together are dissolved (Montgomery & Fewer, 1988, p. 98). These conditions are true of the family as well and the system can become dissolved, so in considering the family system as it plays into the development of eating disorders, the family system is no longer defined by genetics, but rather the existing interactions.
There are many things that can cause a family system to disintegrate, many stressors developing more recently with the changing role of the family. Families are more spread out now than they have been in the past, and the stress of maintaining an extended family can many times promote disintegration. Families also have very little support from this extended family or from social institutions leaving them to have to deal with everyday and extreme circumstances independently. All of this is compounded by the fact that families have very high expectations of their members causing additional stress (Montgomery & Fewer, 1988, p. 99). The family system is weakened by these circumstances, but they do not always lead to disintegration.

There are forces opposing these stressors though, which can help maintain the integration of the family system. When needs are met, both basic ones like being fed and clothed, and more complex, often emotional ones, there is a drive to keep the family integrated because without it those needs may not receive the attention they require. There is also a human tendency to resist and fear change, and from birth one of the constant factors in most people’s lives is their family. The disintegration of the family system would bring about great change that many people do not want to bring into their lives. There is also strong pressure from society to keep the family as intact as possible and remain integrated so people are both socialized to remain in the family and pressured to do so. Aside from these factors, similar to having one’s needs met, being a part of an integrated family system may be quite enjoyable (Montgomery & Fewer, 1988, p. 100). So while there are forces that can make integration difficult, but there are benefits for the individual.
Just as there are pressures to integrate and disintegrate, the individual ties that maintain integration can be either positive or negative. Ties can be supportive of bad or destructive behavior just as easily as they can healthy behavior. These ties can be used as an indicator of the mental health of the family. Often, “a family’s interactions reflect the state of health of the least well member” (Montgomery & Fewer, 1988, p. 101). In the case of eating disorders, the poor interactions may manifest themselves in the eating disordered child.

Within the family, there are three levels: the family, coalitions of members, and the individual members (Montgomery & Fewer, 1988, p. 102). A coalition is a “family subsystem that consist of two or more members” (Montgomery & Fewer, 1988, p. 107). The coalitions can cause many problems because they as interactions can be healthy or unhealthy. They are formed because there are variations in the members of the family that cause them to be drawn to or repelled from one another. When family members are in different moods, they may want to surround themselves with different types of people and will choose specific companions. The different personalities or mutuality of interest of family members may also contribute to the formation of coalitions (Montgomery & Fewer, 1988). One more specific form of coalitions is called triangulation and involves a coalition of two people with a goal.

“Triangulation occurs when two people are in conflict or have a difference of opinion which they can neither resolve nor contentedly live with. Each attempts to make an ally of some other family member in order to ‘win’ and thereby resolve the matter to his advantage” (Montgomery & Fewer, 1988, 108)
Triangulation can be extremely destructive when parents try to get a child to join with them against the other parent. Pressure to choose sides can only hurt the children because it causes them to have to in some way go against one parent or the other. The coalition is also ineffective because the original conflict is never really resolved and will hurt the relationship (Montgomery & Fewer, 1988, p. 108).

Parent child coalitions and triangulation are of particular interest in looking at eating disorders because the dysfunction of the family system caused by the coalition has been suggested as a possible risk factor in eating disorders. When looking at the families of girls with anorexia, parent child coalitions and triangulation are found with considerable frequency (Killian, 1994). The presence of triangulation is frequently cited as common in families of children with eating disorders and is considered a possible factor in their course of development.

For a system to survive, there must be agreed upon parameters set up by the members of the system. The system “requires a shared an accurate view of the immediate world, its continued existence depends upon the system’s ability to handle information” (Montgomery & Fewer, 1988, p. 110). All of the members of the system must agree upon what is considered to be true and what is not. In the family this can have interesting consequences. Because the parents have already matured and begun to navigate the social world, they have their own set of beliefs that they hold to be true. Children enter a family system in which an agreed upon set of information exists, so they have little choice but to accept it as is.
This is extremely important in the case of eating disorders the information about weight that a family system agrees upon can be healthy or unhealthy. It could be considered valid that weight is an indicator of worth or a high value can be placed on thinness and appearances. If these are present an environment exists that is more favorable for the development of eating disorders. Further stress is put on the child because if they do not adhere to these values or agree upon information, then there is stress on the family system. This double-edged sword could then contribute to further stress because of the lack of control and choice for the individual.

The implication of the presence of triangulation and discourse about weight is that one of the factors in the development of eating disorders could be the manner in which the family system interacts and remains integrated. That the system can by itself, without any outside stimulus, crisis, or pressure, create an environment that is suitable for the development of an eating disorder has an effect on how we view the family’s role. That it is the makeup of the system and its interactions rather than stresses on the system that can manifest in eating disorders could provide some explanation why it is the families who normally have the lowest risk all sorts of problems that overwhelmingly more afflicted with this one than other more typically at-risk groups.

**Risk Theory**

Having gained an understanding of family systems theory, one element of the system that it is imperative to examine is risk. Risks are factors that “predispose individuals and populations...to specific negative or undesirable
outcomes” (Cowan, Cowan, & Shultz, 1996, p. 9). Risk theory considers the amount of risk that an individual experiences to be fluid, constantly changing with each change in their life. Some aspects of risk like socioeconomic status or race stay relatively stable, but notably, psychological risks fluctuate considerably between high and low risk (Cowan, Cowan, & Shultz, 1996, p. 7). Risk theory is useful for looking at the case of eating disorders, because many of the risks associated with eating disorders are widespread throughout the population but it is only a few individuals who develop the psychopathology.

The fact that there is such a discrepancy between risk and negative outcome suggests that there must be something else at work. In a causal model, the presence of risk would be directly linked to eating disorders. In the family system, however, the variables of vulnerability and buffering serve to in some way to change predicted outcomes. The vulnerability of an individual is an increase in the likelihood that a negative outcome will occur in the presence of risk. Vulnerability itself will not cause an individual to develop a problem, there must be a risk, but vulnerability instead acts as a catalyst to the development of the undesirable outcome (Cowan, Cowan, & Shultz, 1996, p. 10). Cowan et al. use the analogy of a sailboat to describe the ways that risk and vulnerability interact. A sailboat that has developed a leak is fixed with a patch. The boat can sail with no problem on calm seas, but it a storm, all of the boats in the area could be damaged, but this particular sailboat is more likely to become damaged because of the patch. In this example, the patch is vulnerability and the storm is risk. The patch does not affect the situation until risk is present (Cowan, Cowan, & Shultz, 1996, p. 10-11). In the case of eating disorders, an unidentified predisposition to
the disease is present which in the presence of risk factors could develop into a full blown eating disorder.

This paper has outlined a few of the ways in which a family can create an environment that serves as a risk for eating disorders. As described, risk can be fluid so that the extent to which these factors serve as risks is variable in different situations and for different people, but they have been consistently been identified in those with eating disorders. Those specifically identified include an environment that emphasizes traditional gender roles, the presence of poor family functioning and the presence of a discourse on weight.

The presence of risk factors in the face of vulnerability does not inevitably result in disease however. In the system there can also exist a buffer instead of increasing the chance that a problem will develop in the presence of risk like vulnerability decreases those chances. It is important to note that buffering or protective factors do not in fact lower risk, they simply lessen its effect (Cowan, Cowan, & Shultz, 1996, p. 13). An individual or family that is seen to “thrive on the challenges that adversity sets in motion” is referred to as resilient (Cowan, Cowan, & Shultz, 1996, p. 14). Both individuals and families that create buffers and are resilient are important to the discussion of eating disorders because characteristics of their families and selves could be used in treatment and prevention of the disease. The family, while it can in some instances produce risk, it can also serve as a buffer.

After defining these parts of the family system, it is then necessary to evaluate how these factors function together for the problem one is interested in.
“One of the central challenges of developmental psychopathology is to explain the discontinuities (between risk and outcome) by identifying the buffering factors that protect some children from psychological harm in the presence of risk, and the vulnerability factors that lead some children to develop disturbances despite the fact that their circumstances and family environment would lead us to hold more positive expectations” (Cowan, Cowan & Shultz, 1996, p. 7).

Eating disorders can be looked at as a very interesting study in terms of these discontinuities, because many of what are traditionally considered risk factors for many other problems like minority status and low socioeconomic status are not so for eating disorders. It is the families that have the lowest risk in other situations that produce children who have the highest incidence of eating disorders.

Not much attention has been paid to these factors in the context of eating disorders, but it may be useful to examine general ways in which these factors operate in families to get an idea of how they could possibly do so with eating disorders. A general model can at least inform us on the directions that research should take to examine eating disorders in terms of the family system.

**Supportive Models**

Supportive families generally share a group of characteristics that are assumed to operate in the system as support mechanisms. The majority of these characteristics revolve around effective communication, but there are other skills as well. These families help children to develop coping skills and become competent. It is often necessary for the parent to shield a child from certain experiences that they are not ready for in facilitating the development of coping
skills and competence. Effective communication, while important in and of itself can also help with the challenges of life that are appropriate or inappropriate for their age (Wills, Blechman & McNamara, 1996, p. 112). This support is related to very high levels of coping and competence that is unrelated to other possible factors like socioeconomic status (Wills, Blechman & McNamara, 1996, p. 110). That support is unrelated to such factors suggests that it is a product of the family system’s interactions rather than outside factors. These supportive functions have been noted as being most important for adolescents that have high stress levels because they do in fact have a buffering effect for challenges that the child will face (Wills, Blechman & McNamara, 1996, p. 116).

This model uses the term challenge is a similar way to the manner in which we have previously described risk. “A challenge is an event or circumstance that threatens a child’s self-esteem, mood, interpersonal relationships, or accomplishment tasks” (Wills, Blechman, & McNamara, 1996, p. 108). A challenge could be considered with the category of risks that are fluctuating and fluid rather than the ones that remain somewhat stable. Challenges can be unexpected problems, but they can also be normal developmental tasks that a child must conquer in the journey towards maturity. Learning to sort out problems on the playground is something that a three-year-old might not be ready for but a six or seven year old must learn how to do themselves in order to be able to develop social relationships. A challenge could just as easily, though, be the death of a parent or loved one, something that is unexpected and occurs blind of age.
The challenges can then be mediated by the presence or absence of the qualities of supportive relationships discussed above. “The functional model (of social support) proposes that interpersonal relationships enhance adaptation through provision of supportive functions that are of direct or indirect assistance for the coping process” (Wills, Blechman & McNamara, 1996, p.109). Direct assistance involves facilitating overcoming challenges in a physical or tangible way whereas indirect assistance is often more emotional in nature and takes the shape of supportive relationships like the families discussed above. The indirect assistance causes a child to be able to take more on because of the feelings that they are given from the supportive relationship (Wills, Blechman & McNamara, 1996). It is easier to go out on a limb if you feel that there is someone there to catch you.

This model of supportive relationships again emphasizes that the family can, through its integration and interactions, affect the way that a child develops. In this case, the focus is now on the outcome of the addition of outside stress. If a family has stress from within the system, achieving the level of support that is shown to help family members cope could be more difficult than if the only significant stress comes from outside of the system.

It is the family system then that is responsible for many of the factors that have been identified by this discussion as risk factors for the development of eating disorders. Why the functioning of a system does not create gender stereotypes or cause parents to accept them, it does prevent members from being able to fully reject them. The system has the capability of reinforcing many unhealthy beliefs in this manner. Poor system function can also lead to a lack of
support, something that is crucial during the time period in which eating disorders develop. Adolescence is a time of great change, and as noted before, this can be very stressful for young women. The rigidity of the families with individuals with eating disorders prevents them from being able to fulfill the supportive model of family functioning. While the system does not create the problems, it is an extremely useful tool for examining how family weaknesses can work to create disorder.
Conclusion

This examination of the families of the victims of eating disorders begins to show the impact that the family can have on the mental health of its members. As a source of a tremendous amount of social interaction as well as complicated interpersonal relationships, the family is an enormous factor in the development of its members. From the evidence presented, it is clear that the family is an important variable that deserves attention and further consideration.

As gender is a very significant factor in the development of eating disorders, the fact that parents play such a large, active role in its development begins to reveal some of the forces that are at work. It is not surprising that poor family functioning could play a role in the creation of an unhealthy environment or that emphasis on weight could increase the chance of disorder. It does however highlight how important it is to examine the family to gain some understanding that could lead to improvements in treatment.

It is extremely important to note, however, that the scope of this paper is quite small and there are many areas that it did not address. Fully researching eating disorders thus calls for new research and further research in this same topic area. Not only does it single out the family as the only area of interest, but it only addresses a few aspects of family influence and functioning. The area of the family deserves a great deal more attention in the future. For example, this paper fails to address an individual’s roles within the family and how that can affect an individual. It generalizes the role of the family by focusing on only system
functioning problems and net delving into the details of the complicated interpersonal relationships.

While there was a brief summary, the paper did not focus on an analysis of the makeup of the family either: divorced or married, number of children, gender of children, etc. In short, the family is tremendously complicated and this inquiry only scratches the surface.

Some additional very important variables that have been largely ignored by this examination include the peer group and factors within the individual, both of which cannot be disregarded. Seeing as the time of peak onset for eating disorders is in adolescence, the peer group and the environment that it creates are likely enormous factors in the lives of the adolescent girls stricken with disorder. Not only do they also provide interpersonal relationships much in the same way that a family might, they also will provide pressures and may influence a girl’s view of gender tremendously. All of this has been ignored for the sake of zeroing in on the family.

All of the past discussion also only addresses trends among those who have eating disorders and their family. There is no discussion of the individual risk factors or personality traits that could also play into the development of the disorder. Research into this area is complimentary to the above inquiry because the family creates an environment where risk and vulnerability collide, making research into individual risks necessary for the bigger picture.

Looking at family functioning begins to paint a picture of the environment in which eating disorders develop, but the picture is far from complete. Knowing that family functioning and the impact of family on gender development can
provide some insight for treatment and prevention, but there is still a
tremendous amount to be learned.
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