Family Therapy for Adolescent Anorexia Nervosa

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Successful treatment of anorexia nervosa remains elusive for many cases. Involving the family in the treatment of adolescents with anorexia nervosa has proved to be of benefit for young clients with a short duration of illness. In fact, the benefits of family therapy have been shown to be enduring at five-year follow-up. Engaging in treatment and commitment to therapy are important factors affecting treatment outcome. For instance, parental criticism of the anorexic offspring can lead to early dropout of treatment or poor outcome in treatment. The case presented in this article demonstrates how the family's help can be solicited in restoring the adolescent's health in much the same way had the client been admitted to a specialist inpatient facility. Although the treatment in this case was relatively uncomplicated and brief, the family had to overcome their initial exasperation with the client's self-starvation in order to be helpful in the process of the adolescent's weight restoration. When this initial stumbling block was resolved, in part by the therapist's modeling of an uncritical stance toward the client's dilemma, the family was successful in nurturing their daughter back to health. Once the client's weight was restored, and the adolescent reintegrated with her peer group, she could negotiate her continued individuation from her parents, but without the eating disorder to cloud their relationship. J Clin Psychol 55: 727–739, 1999.

Anorexia nervosa is a serious illness characterized by the client's persistent dieting in order to lose weight, often to the point of severe malnutrition. The continuous dieting and concomitant weight loss usually lead to an endocrine disorder and are accompanied by a specific psychopathology, which consists of a morbid fear of fatness (Russell, 1970). This weight loss often leads to major medical complications, some of which are irreversible (Andersen, 1992). Anorexia nervosa usually follows a prolonged course and is associated with high morbidity; recent long-term follow-up studies have also indicated a high mortality rate (see, for example, Ratnasuriya, Eisler, Szmukler, & Russell, 1991). Although

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there is little evidence that the overall incidence of anorexia nervosa is increasing, there has been an increase in eating disorders in the most vulnerable group of females, those aged 15 to 24 years (Hoek, 1997). Anorexia nervosa has been described in modern psychiatric nomenclature for almost 30 years; despite this long-standing recognition, treatment of anorexia nervosa remains complicated for many clinicians and represents a significant struggle for most clients.

Treatment of anorexia nervosa has traditionally relied on inpatient care, and the first priority in this process is weight restitution. Restoring the weight of an anorexic client in an inpatient setting is relatively uncomplicated and has been well described previously (Russell, 1983). For most clients, the process of normal body weight restoration takes between 10 and 14 weeks. After discharge from hospital, clients are managed with outpatient supportive psychotherapy, nutritional counseling, and regular monitoring of weight and physical health. Despite these efforts, many clients lose weight after discharge and a significant number relapse to the extent that they have to be readmitted.

Although psychotherapy is generally considered crucial in the treatment of anorexia nervosa (American Psychiatric Association, 1993), few controlled studies investigating its efficacy have been carried out. A handful of studies that examine the effectiveness of individual or family therapy in adolescent anorexia nervosa is available (Crisp et al., 1991; Le Grange, Eisler, Dare, & Russell, 1992a; Robin, Siegel, Koepke, Moye, & Tice, 1994; Russell, Szmukler, Dare, & Eisler, 1987), all of which have involved the client's families in their treatment of clients. The most influential of these findings derives from a large controlled study by Russell and his colleagues at the Maudsley Hospital in London. The design of this study followed the traditional research format, and 80 clients with an eating disorder were randomly allocated to the treatment under study (family therapy) or the control treatment (individual therapy). The most significant results were found in one of four subgroups of clients: adolescent anorexia nervosa clients with an onset of illness before 19 years of age and a duration of illness of less than 3 years. In this group, family therapy was clearly superior to individual therapy.

THEORETICAL FOUNDATIONS OF FAMILY THERAPY FOR ANOREXIA NERVOSA

Before describing the Maudsley model of family therapy for anorexia nervosa, a glance at the work of our predecessors is in order. The earliest descriptions of anorexia nervosa in both the English and French literature ascribed a crucial role to the way in which the client and the family interact, and the way in which this interaction influences the development and outcome of anorexia nervosa. Many early observers were of one voice in expressing exasperation with their client's families, believing that the familial influence is harmful and that parents lack "moral control" over the client. Instead of incorporating work with the family in the course of their clients' therapy, these observers recommended the parents' exclusion from treatment (Charcot, 1889; Gull, 1868; Lasegue, 1873).

Influential authors in the 1970s were more inclusive of the families of clients, and described their treatment for anorexia nervosa based on the premise that there are "interactional difficulties" between the clients and their families (for example, Minuchin, Rosman, & Baker, 1978; Selvini-Palazzoli, 1974). These authors' work undoubtedly strengthened the belief that families of anorexic clients have "specific qualities" that should be addressed in the treatment of anorexia nervosa. The most elegant description of the observed clinical features of these families is that provided by Minuchin and his colleagues at the Philadelphia Child Guidance Clinic. They maintain that families with an anorexic child can be characterized by specific transactional characteristics: *enmeshment*, *overprotectiveness*, *rigidity*, and *lack of conflict resolution* (Minuchin et al., 1978).

These authors assert that anorexia nervosa is associated with characteristic dysfunctional familial patterns, and that treatment should be directed toward changing these family processes or structures, which are believed to have triggered and maintained the adolescent's psychosomatic symptoms. The therapist is required to conceptualize the illness in terms of the organization and functioning of the entire family and to plan therapeutic interventions to induce change in the family. Consequently, it is often believed that families may play a role in maintaining anorexia nervosa.

TREATMENT PRINCIPLES OF FAMILY THERAPY FOR ADOLESCENT ANOREXIA NERVOSA

More recent thinking from the Maudsley group in London takes the approach that there is no evidence that families produce anorexic individuals (Dare, Le Grange, Eisler, & Rutherford, 1994). Whereas certain family characteristics may influence compliance with and responsiveness to family therapy, families are, in fact, helpful in treatment. The Maudsley approach is strongly influenced by the work of Selvini-Palazzoli and Minuchin, and combines what is believed to be the two major components of family therapy for anorexia nervosa. The first component is a problem-solving approach (Haley, 1973), whereas the second component maintains that viewing the family as a system provides unique insight into symptom-maintaining interactional patterns. With the aim of restoring the adolescent anorexic's health, family therapy for adolescent anorexia nervosa usually proceeds through three clearly defined phases. This therapy is time limited, and success depends to a large extent on the therapist's ability to make a strong therapeutic connection with the family.

First Phase: Refeeding the Client

In the first phase, treatment is focused on the eating-disorder symptoms, and may include a family meal as described by the Philadelphia group (compare Rosman, Minuchin, & Liebman, 1975). Such an occasion provides the therapist with an opportunity for direct observation of the familial interactional patterns pertaining to eating. This phase is characterized by attempts to absolve the parents from the responsibility of causing the illness, and by complimenting them on the positive aspects of their parenting. With younger clients the therapist makes careful and persistent requests for united parental action directed toward eating. On the one hand, the therapist directs discussion to create and reinforce a strong parental alliance in their efforts to refeed their offspring—an alliance of major importance, because parents are often at odds about how to proceed with this task. On the other hand, the therapist aligns the client with the sibling subsystem to reinforce appropriate distance between siblings and parents, and to provide an opportunity for the siblings to be supportive of the client. Throughout this phase, the therapist will demonstrate to the client an understanding of the client's predicament in being consumed by the eating disorder and having her parents "take away" her only sense of identity. Families are encouraged to work out for themselves how best to refeed their anorexic child.

Phase Two: Negotiations for a New Pattern of Relationships

The start of the second phase is signaled by the client's acquiescence to the demands of the parents to increase the client's food intake, as well as a change in the mood of the family. Although symptoms remain central to the discussions, weight gain with minimum tension is encouraged. In addition, all other issues that the family has had to postpone can

now be brought forward for review. This, however, occurs only in relationship to the effect these issues have on the parents in their task of assuring the client's steady weight gain.

Phase Three: Termination

The third phase is initiated when healthy weight has been achieved and self-starvation has abated. The central theme here is the establishment of a healthy adolescent or young adult relationship with the parents in which the illness does not constitute the basis of interaction. This entails, among other issues, working toward increased personal autonomy for the adolescent, establishment of more appropriate family boundaries, and emphasizing the need for the parents to reorganize their life together after their children's prospective departure from home (Dare, Eisler, Russell & Szmukler, 1990).

CASE ILLUSTRATION

Presenting Problem/Client Description

Sarah was a 15-year-old tenth-grade adolescent with a 6-month history of food restriction, excessive exercise, and weight loss (25 pounds in 6 months). Sarah's mother, a health care worker, made the call to my office expressing concern about Sarah's precipitous weight loss, and described her daughter's urge to exercise at every opportunity, and said that Sarah was becoming more withdrawn. Sarah's pediatrician had seen Sarah a few times prior to the mother's call. Although routine laboratory investigations showed no abnormalities, the pediatrician shared mother's concern about Sarah's weight loss. In the past month, the mother had also taken Sarah to a counselor to discuss Sarah's difficulties—but Sarah experienced the session as an invasion of privacy and decided not to return. Mother said that Sarah's father, a successful business executive, shared her concerns about Sarah and believed that additional treatment options should be taken to address their daughter's eating disorder. Sarah's brother Patrick, 14 years of age, was said to be "very worried" that his sister did not "eat anymore," and appeared "different and isolated." Sarah's maternal grandparents lived a few blocks away, and Sarah's relationship with them was described as "very close."

Case Formulation

Mother was clearly worried about Sarah's weight loss, and although it appeared as if other members of the family shared the mother's concern, this hypothesis needed to be explored. Father's role in the family was uncertain. That is: Was he aligned with the client and urging more time? Or was he distant and left mother to deal with their daughter's eating difficulties? Even though the client's brother appeared to be distressed, his support for his sister needed to be clarified. That is: Was he her peer? Or was his role more that of a parental child? Similarly, the grandparents' involvement with the family in general, and in Sarah's upbringing in particular, was uncertain, and needed to be explored further.

Because of Sarah's young age, and the early onset and short duration of her eating difficulties, the therapist's initial goal was to meet with *all* family members living in the same household in order to make an assessment of the client and her family. More specifically, my aim in treatment was to make a thorough assessment of Sarah's eating disorder and to focus the family toward resolving Sarah's self-starvation—that is, my

goal was to help the parents take charge of Sarah's eating, while getting her brother to support her through this period. The grandparents' constructive involvement, or appropriate distance, was a secondary goal at this early stage of treatment.

Course of Treatment

The therapist's initial task—before the first session can commence—is to set up the family meeting. By setting up the initial family meeting, the therapist begins the process of defining and enhancing parental authority with regard to the management of the crisis. I used the initial telephone contacts with the mother to emphasize that there was a crisis in their family—that is to say, I pointed out that Sarah is starving, the family should respond to this crisis, and all family members who share a household with Sarah should help in this matter.

Although this may seem like a straightforward arrangement, it requires firmness and tact. Consequently, I began by putting forward a convincing request to the mother that all those living in the same household should attend. I also inquired about the client's grandparents and the extent to which they were involved in Sarah's care, as she often spent significant time with them. The therapist suggested that it might be appropriate to meet with the grandparents in the near future, but that it would be proper for members of the immediate household to attend the first meeting. In closing, I told the mother that I would make arrangements to weigh Sarah once the family arrived at my office, but that she should bring recent physician reports about Sarah's health.

Session 1. All members of the household arrived for the first meeting. They seemed anxious about the meeting as I accompanied them to my office. Sarah was a tall, casually dressed adolescent, who came across as shy; she looked frail, pale, and had dark rings under her eyes. Back in my office, I shook hands with everyone, again making sure that no one was overlooked—by getting their names, noting what they did for a living, and ascertaining what their understanding was of the purpose for this meeting. To convey the seriousness of this illness to the family, I greeted them with foreboding and in a style that can be characterized as intense, warm, and empathic.

Engaging eating disorder clients and their families in treatment is often a profound challenge, and the outcome of treatment is affected by the degree to which the therapist succeeds in this task. The style in which the therapist greets the family is complex and is designed to set up a *therapeutic bind*—that is, the therapist is the deliverer of distressing news and at the same time a kind caregiver who communicates this concern in a warm and caring tone.

THERAPIST: Sarah is desperately ill and you will have to take very drastic action to save her life. You must be very troubled by what's happened to her and worn out by the events of the last six months. Not knowing which way to turn to make things better for Sarah must play on your minds all the time.

What I was attempting here was to raise the parents' concern about Sarah as much as possible, and at the same time be warm and positive about the family—thereby reducing any parental guilt. The parents' concern is raised so that they can be mobilized to take charge of Sarah's refeeding. To do this, I made sure to get a detailed account from each family member as to how they perceived Sarah's state of ill health, including one from Sarah herself. *Circular questioning* is often helpful in allowing family members to provide their unique insights about family life. Instead of just asking father or mother how

much they worry about their daughter not eating, the therapist asks a third party to describe the specific event. In this case Sarah's brother was asked a question.

THERAPIST: What does your Mom do when Sarah struggles to eat? And can you tell me what your Dad typically does to encourage Sarah to eat more?

The next step was to reflect the family's comments back to them in such a way that it amplifies the seriousness of the problem and their sense of having done all they could to help, but to no avail.

THERAPIST: So what I hear is that all of you, your primary care physician, and a counselor have tried very hard to help Sarah recover from this dreadful illness, and still the anorexia is showing no sign of letting go. In fact, what I hear is that it has overtaken almost every aspect of her life, so much so that she will die unless you succeed in nourishing her back to health.

On a similar theme as the above, the next step was to orchestrate an "intense scene" around Sarah's illness, the aim of which is to raise the parents' concern and sense of responsibility sufficiently so that they can take on the task of getting Sarah to eat. In raising the parents' concern, the intense scene should neither scapegoat Sarah as having caused her family this distress nor blame the parents for Sarah's illness. The focus of this trepidation was Sarah's weight (68% of Ideal Body Weight on first assessment), the physiological and psychological consequences of her starvation, the previous failed attempts at engaging her in treatment, and presenting the concept that within the family lies the last resort for the client's recovery.

THERAPIST: Sarah is dangerously ill and you have no choice but to step in and rescue her. Most parents have a variety of ways in which they approach everyday dilemmas in their families. You as a couple may have some issues that you differ on, and that is okay. However, when it comes to working out a plan about how to nourish your child back to health, you cannot afford to disagree about what steps are necessary to take. If you disagree about this task, it will be easier for the eating disorder to stay in charge of your daughter's life and ultimately defeat her.

Sarah had undergone limited treatments prior to this consultation: Although the "inability" of past health care professionals' efforts should be treated respectfully, this circumstance should also held out as evidence of the dire position in which the family finds themselves. To get the parents to refeed their daughter, a task that is uncomfortable for most parents, the therapist should separate the illness from the client. In stressing that Sarah had little control over her illness, I tried to enable the parents to take drastic action against the *illness*, as opposed to their *daughter*, who was so frail looking. I therefore modeled support for the client who was overtaken by this illness, while at the same time counteracting or modifying any criticism from the parents or her brother toward Sarah. Information about how devastating the illness is and how the parents have to work hard at combating its effects were clearly upsetting to Sarah. She became even more withdrawn at this time and lifted her head only occasionally to look at the clock on the wall. I tried to demonstrate to her that I accepted her dilemma and fear—*dilemma* in that she is not understood and that I might be exaggerating the problem, and *fear* in that I would be rallying the parents to take away the control Sarah thinks she has over her eating.

THERAPIST: I am very saddened that this terrible illness has overtaken your life to this degree, that it has taken your freedom away, and that it has left you without much

control of what you think and do. Most of your thoughts and behaviors around eating have been overtaken by the anorexia, and the only way forward is for your Mom and Dad to help you regain the weight you have lost.

The theme here was to show Sarah that, although I understood her predicament, we had to remain committed to the primary treatment goal, which was for her to gain weight. To stay committed to this goal while expressing an understanding for the client's fears is a challenge for most therapists. In showing support and understanding for Sarah's dilemma, I demonstrated sympathy for her position. However, because I also wanted to preempt any criticism of Sarah from either her parents or her brother, I needed to address the family's dilemma of trying to understand why their daughter is behaving in ways they might not understand, while addressing the issue of her weight loss.

THERAPIST: The symptoms don't belong to your daughter. Rather, it is this terrible illness that has overtaken her and is determining almost all of her thoughts and activities. For instance, it is the anorexia that makes her hide food, or dispose of food, gets her to insist on preparing her own food, drives her to exercise at every opportunity she can get, and makes her behave in deceitful ways. In other words, it is the illness that gets your daughter to do all these things that you find so upsetting. The Sarah you all knew before this illness took over is not in charge of her behavior, and it is your job to strengthen the healthy Sarah once more.

The therapeutic goal was summarized at the end of the first session. The reasons for this were (i) to leave the family with a sense of responsibility to take on the task of refeeding their daughter; (ii) to alert them not to engage in discussions about diet foods; and (iii) to emphasize that they should nourish the client with regard for her profound state of malnutrition—and point out that Sarah's vegetarianism may have to be suspended until she became healthy again. Sarah's parents seemed somewhat overwhelmed by my suggestion that *they* ought to restore her health, and it was apparent that these feelings needed to be addressed.

THERAPIST: I realize that you may be troubled—thinking that you have come to me for help with your daughter, and here I put the ball right back into your court. However, we really don't have any alternatives that can secure Sarah's well-being in the long run. Surely we can try and arrange for her to go into hospital, which may even have the desired effect in the short term. I have to remind you, though, that most clients lose weight once they are discharged and then you have to face the same dilemma once more. If you can do this job yourselves, then you can give your daughter the best guarantee to recover fully.

In summary, the family was invited to return within the week, and was asked to bring an afternoon snack with them, because I was interested to observe some of their family rituals with regard to eating. The therapist's assessment confirmed Sarah's anorexia nervosa, restricting type, weight at 68% of Ideal Body Weight, and primary amenorrhea. Sarah obtained a global score of 4 on the Morgan-Russell Assessment Schedule (1975). The global score is a composite score of five subscales that measure the clinical status of clients, taking weight, menstrual status, mental status, psychosocial, and psychosexual development into consideration (high score = healthier client; 12 = maximum).

Session 2. The goal of this session was to continue with the family assessment, but this time in the context of observing the family engaging in eating a snack. In principle, this

affords the therapist an occasion to evaluate the family's transactional patterns around eating, and provides an opportunity to support the parents in their efforts to refeed their daughter. At the same time, the therapist makes sure the client feels supported by her siblings while the parents increase their efforts at refeeding the adolescent. From a theoretical perspective, the therapist wants to disrupt cross-generational coalitions between the anorexic adolescent and an overprotective parent. For example, the overprotective parent may collude with the client's symptoms and agree that the quantities of food are too great, whereas the other parent takes a firm stance and compels the client to eat. The family meal is an atypical occasion, because each family displays its own mealtime rituals.

Even though I invited Sarah's family to bring along a light snack, it was evident that the meager helpings Mom offered Sarah were inadequate and insufficient to promote weight gain. To get the parents to chose calorie-dense foods, I had to encourage them (without sounding judgmental) to delve into their resources about appropriate feeding for a growing child.

THERAPIST: You have to provide your daughter, who is starving, with the kinds of food that would restore her weight to normal. Snacks like a granola bar or a plain bagel are appropriate for someone not in need of weight gain. However, to correct Sarah's starvation and help restore her weight, it is bagels with cream cheese, pasta with a cream sauce, or potatoes and rice with gravy that will do the job.

The meal helped unfold the interactional patterns of the family around eating. I did not participate in the meal; instead, the event served as an opportunity to learn more about the family's style of eating together by observing their rituals, and by asking questions about eating. The reason for this inquiry was to help the therapist understand what potential changes in these activities would be advisable.

It soon became apparent that Sarah was not going to heed her parents' request to eat her snack or drink her juice. For a while I just sat back and observed what was happening around their efforts to get Sarah to eat. Everyone was quiet while the mother, in a soft voice, tried to cajole Sarah into eating. Sarah, on the other hand, was more vocal and made it quite clear that she was not interested in having what was offered. During these efforts, the mother occasionally looked my way, partly out of desperation and perhaps hoping I would be able to step forward and be of more direct help. Instead I kept my inquiries to "whether this is typical of their struggle at home" or, if it were not representative, to let me know how it would be different. At this point I was interested in seeing how the family would manage refeeding if Mom *and* Dad applied more pressure to Sarah. The parents were instructed to make another effort to get Sarah to eat her snack. This time the therapist showed consistency in coaching the parents by making repetitive suggestions as to how they might act, in order to compel them to increase gradually the monotonous message they should apply to their daughter—that is, to convince Sarah to eat. To help bolster the parents' confidence, it is often helpful to remind them of a time when their daughter was even younger and ill in bed with a bad head cold and they tried to get her to eat or to take her medicine.

THERAPIST: Think back to a time when Sarah may have had a bad cold and you wanted her to take her medicine or have something to eat, and you succeeded. This is because you know how to feed a starving child and you don't need expert nutritional advice. It is the eating disorder that makes you doubt your expertise.

The parents were being empowered and coached as to how they might proceed at the *next* mealtime at home. The role assigned to Sarah's brother was one that does not inter-

fere with the parents and their task at hand. Sarah's brother Patrick was therefore reinforced for uncritical support and sympathy for his sister—that is, for establishing a healthy sibling subsystem in aligning the client with her sibling as opposed to being coopted into a parental alliance that would ultimately sustain the eating disorder. I demonstrated to the client that I understood her dreadful predicament. At the same time, I turned to Sarah's brother and encouraged him to be supportive of his sister—not in her efforts to be anorexic, but in comforting her when she felt overwhelmed by the turn of events.

THERAPIST: While Mom and Dad are working hard to fight your illness and nourish you back to health, you may think that they are being awful to you, and you will need to be able to tell someone just how bad things are for you. (*Turning to brother*) She will need someone like you who can listen to her complaints and comfort her when she feels that things are too rough for her and she gets too scared about eating and gaining weight.

Sessions 3 to 10. The goals for the remainder of the first phase were (i) to keep the family focused on the eating disorder; (ii) to maintain continued support for the parents in their efforts to refeed their daughter; and (iii) to mobilize Patrick to support his sister through this process. Unlike the more structured nature of the first two meetings, the remainder of the first phase was less systematically organized, and sessions did not follow a prespecified order. Instead, a combination of these goals applied until the conclusion of the First Phase.

The groundwork to enable the parents to take charge of Sarah's eating was prepared in the first two sessions. In general, because of the illness' tenacity as well as the varying level of parents' skill and ability to unite in refeeding their offspring, the therapist should continue to coach and cajole the parents in their refeeding efforts for the remainder of this phase of treatment. Although the father appeared removed from this process on a day-to-day basis, he was consistently supportive of the mother's more direct efforts throughout treatment. They appeared comfortable with this task differentiation in the process of refeeding; once the client learned that her parents were not going to allow her to starve herself, she did not resist their efforts at refeeding. I also wanted to make sure that Sarah's meals with her grandparents were being supervised adequately, and invited them along for a session in which the immediate treatment goals were reviewed and their cooperation solicited. They were supportive of the treatment efforts.

Each session started by recording the client's weight. The weight was carefully noted on Tanner and Whitehouse's (1986) weight charts, which was always shared with the entire family. I explained to the parents how the client's weight compared with her peers, and congratulated everyone in the family when progress was made. At this early stage of treatment, I continued to point out just how dangerously underweight Sarah was, even though her weight was progressing well. This was done in order to keep the parents' focus on the task at hand, because I was concerned that they might take premature comfort from her initial weight gain and relax their vigilance. The therapist had to demonstrate determination to stay with the eating-disorder symptoms in order to send a powerful message to the parents that, for now, refeeding is the focus of treatment.

THERAPIST: I am really happy to see how Sarah's weight is progressing, which means that you are doing a great job. However, we shouldn't lose sight of the fact that she remains desperately ill, and it is very important for you to remain focused on the task of getting her to eat what you think is appropriate given our goal here.

At most ensuing sessions, I carefully reviewed events surrounding eating during the past week and discussed Sarah's performance on the weight chart. The family's strategies to bring about weight gain dominated discussions. The parents, the client, and her brother were all asked about events of the past week, and how they went about the task of refeeding. It was apparent that, initially, the mother would spend a great deal of time explaining to Sarah why she should be eating the food the mother had prepared, whereas the father kept somewhat of a distance when Mom and Sarah got stuck in "anorexic debate"—that is, arguing about the value of one food item over another—with Mom usually losing the argument. Patrick said that this would upset him, and consequently completed his meal quickly so that he could be excused. In the same style of *circular questioning* outlined before, I verified each response with every family member in turn, to determine how each individual would characterize the described events. It was important that discrepancies were examined carefully, because this clarification helped the therapist to select and reinforce those steps the parents had to take to improve their refeeding efforts. For example, Mom's persistence and Dad's support of Sarah's efforts were reinforced, whereas getting stuck in anorexic debate was discouraged. The therapist should use these initial sessions carefully to bolster the parents in their knowledge of nutritious and high-density meals and reinforce their efforts to bring about healthy eating and weight gain.

The therapist refrained from setting a specific target weight. Instead, percentile positions were used to guide the client toward a healthy weight. This weight is essentially a range that the client can maintain without undue dieting and at which menses is comfortably maintained. Because Sarah had primary amenorrhea, it was not possible to use her menstruation weight as an initial target in this process. (For clients with secondary amenorrhea, weight at which menses were maintained before the onset of illness is used as a minimum target weight.)

THERAPIST: You have done an excellent job with your two children—until Sarah's illness has outsmarted you. Your fine parenting abilities are clearly evident in the way Patrick is thriving, and the way in which Sarah has thrived before the illness got the better of her. There is no reason why you shouldn't be back on track with Sarah pretty soon too.

To reinforce healthy boundaries between the generations, and to prevent Patrick from interfering with his parents' task of refeeding, I encouraged Patrick to show consistent support for his sister throughout this struggle. Aligning the siblings (Sarah and her brother) in this way made the parents' immediate task less difficult. Patrick was very worried for his sister and wanted to help at mealtimes, and he had to be reminded that his job was to comfort his sister, whereas his parents had to get on with the refeeding.

The goal here was to demonstrate to Sarah that I understood her predicament—that is, I realized she was consumed by her eating disorder, that she felt I unleashed her parents to take away her only sense of identity or power, and that she might feel entirely unsupported while this is going on around her. For this reason, and similar to the stated aim in the second session, I was consistent in encouraging Patrick to support his sister throughout this ordeal. In the beginning Patrick expressed exasperation at not knowing how to approach Sarah, and that, even though they had a good premorbid relationship, she did not seem to want to talk to him that much anymore. He was very affectionate during the sessions and often gave her a hug when she gained weight and told her how much he loved her. During the early part of treatment, Sarah was not necessarily that forthcoming toward her brother. Instead, she kept to herself and only occasionally gave him appreciative glances.

The start of the second phase of treatment was signaled by Sarah's surrender to her parents' demands to increase food intake, accompanied by steady weight gain as well as the parents' relief after having taken charge of the eating disorder. However, addressing the eating disorder symptoms, while continuing weight gain with minimum tension or criticism, remained central in the discussions that followed. In the second phase, though, those issues the family had previously postponed were brought forward for review. In addition to consistent parental management of eating disorder symptoms, the remaining treatment goals were for the parents to relinquish control over Sarah's eating, and to begin some discussion about Sarah's transferring to another school (as she had wished), and plans for Sarah to return to the activities she used to enjoy, such as playing tennis and going out with friends.

Because Sarah's weight gain was still fragile at this early stage of the second phase of treatment, I had to make sure that the parents gradually relaxed their vigilance in the refeeding process. As in the first months of treatment, I insisted that the parents remain relentless until they and the therapist were convinced that Sarah no longer doubted their ability to prevent her from starving herself.

Once Sarah's weight began to approach 90% of Ideal Body Weight, it seemed prudent to guide the family toward relinquishing their control over the client's eating. After twelve weeks of treatment, Sarah's weight was much improved, and I felt reassured that weight gain would continue even if the parents were to exert less vigilance. There was a variety of ways in which the parents gradually reduced their control over this process. Because of Sarah's age and increasing independence, as well as her commitment to vegetarianism on moral grounds, the parents first allowed Sarah to make some vegetarian choices for mealtimes, while still preparing meals herself. The next step was to have Sarah take care of breakfast and school lunch without supervision; later on, the parents allowed Sarah to eat dinner out with her school friends.

The task of the therapist here was to assist the parents and the adolescent to bring about a careful and mutually agreed upon transfer of responsibility in this domain back to the adolescent. Once the eating ceased to be the focus of discussions, the family was engaged in talking about adolescent issues that came to the fore as Sarah was recovering from her eating disorder. The aim was to assist the client in negotiating adolescence and young adulthood successfully. By this time, Sarah was happily settled into her new school and engaged with her peers. She had also returned to playing tennis regularly, which she said she was enjoying. Also significant was that Sarah had started dating. This aspect of her recovery perturbed the parents, especially father, in that the boy was older than Sarah and had recently graduated from high school. The parents were keen to protect Sarah, while at the same time taking cautious delight in the fact that she was exploring adolescence without the interference of the eating disorder. An important shift in the parents' thinking here was their concern for her being ready to start dating as opposed to worrying about her food intake. We could, of course, only engage fully in discussions regarding the issue of seeing their adolescent offspring participating in age-appropriate activities because we were reassured that Sarah's eating was healthy and back on track.

The third phase of treatment was brief, and was initiated when Sarah achieved a stable weight, her self-starvation had abated, and her control over eating had been fully returned to her. The central theme here was the establishment of a healthy adolescent–parent relationship in which the illness no longer constituted the basis of the family's interaction. This entailed working toward increased personal autonomy for Sarah, expressing my understanding of the parents' concerns, but helping them respect appropriate intergenerational family boundaries. Therefore, the goals for the conclusion of treatment were to establish that the adolescent–parent relationship no longer required the symptoms

as an idiom of communication, and to review Sarah's plans to spend more time away as she was preparing for her eventual departure from her family home. Treatment was terminated after four months, when Sarah's weight was at a healthy level and she was on her way to negotiate young adulthood without the constraints of her eating disorder.

Outcome and Prognosis

Sarah and her family were contacted for a follow-up assessment about one year after we terminated treatment. A student who was not involved in Sarah's treatment conducted the assessment. Sarah's weight was stabilized above 90% of Ideal Body Weight and she had started to menstruate, although cycles were still irregular. Her Morgan-Russell Assessment Schedule global score increased from 4 to 10, which put her in the good outcome category according to this scale. She was enjoying school and her friends, and was dating regularly. During this assessment, Sarah and her parents were also asked about their experience of the treatment. Both parents and Sarah felt that the treatment was helpful and informative. The parents were revitalized in particular by the fact that the therapist had helped them to accept that they should encourage Sarah to eat, and that they did not feel threatened or criticized: "Treatment helped us divorce anorexia and the person. This made it easier to cope with and not get angry with Sarah. It helped us to be decisive as a couple and gave us direction." Although a forecast should always be made with caution, considering Sarah's progress in treatment, her clinical status at follow-up, and the family's continuing healthy management of her individuation, it would be fair to say that Sarah has a good prognosis and, it is hoped, will stage a full recovery in the years ahead.

CLINICAL ISSUES AND SUMMARY

Engagement in therapy and the family's continued commitment to treatment are crucial for the successful resolution of the eating disorder. One tool that has proved helpful in the measurement of the relationship between family organization and treatment compliance and outcome is parental criticism of the anorexic offspring as delineated by the Expressed Emotion (EE) scales (Vaughn & Leff, 1976). In a series of Maudsley studies it was shown that high levels of EE in mothers predicted early dropout from family therapy but not from individual treatment (Szmukler, Eisler, Russell, & Dare, 1985). There is also a connection between EE and response to treatment. Criticism of the client by either parent at the onset of treatment was highly predictive of poor outcome. More tentatively, clients from critical families fare better in family counseling (parents are seen separately from the client) as opposed to conjoint family therapy (Le Grange, Eisler, Dare, & Hodes, 1992b). As for Sarah's treatment, the therapist had to be careful to address the mother's signs of exhaustion with refeeding, and the tendency for her and the client's brother to become critical of Sarah's behavior during the early part of treatment. It was therefore imperative for the therapist to model an uncritical stance toward the client, while at the same time avoiding any blame of the family for Sarah's illness. Conjoint family therapy, such as in Sarah's case, when parents are critical of the client at the outset, may exacerbate these deleterious qualities of family life and can have a negative impact on treatment outcome.

In summary, family therapy for adolescent anorexia nervosa with a short duration of illness, in the majority of cases, enables recovery without admission to hospital. Successful restoration of an adolescent's health through weight gain depends on the parents' ability to refeed their child in much the same way as the nursing staff would have if the

client had been admitted to a specialist inpatient unit. Two controlled studies have shown that weight as well as psychosocial functioning can be restored for most adolescent clients in a relatively short period of time (Le Grange et al., 1992a; Russell et al., 1987). Most important from the perspective of this article is that the enduring benefits of the treatment described herein has been demonstrated for this subgroup of clients during the course of five years (Eisler et al., 1997).

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