

## Chapter 40

# Family Therapy for Eating Disorders

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### INTRODUCTION

**F**amily therapy was first described as a primary psychotherapeutic modality for anorexia nervosa by Minuchin in 1970 [1]. In that description and subsequent work, Minuchin and colleagues have identified dysfunctional aspects of family interaction in families with anorectic members and formulated specific family-centered interventions to respond to symptoms of the anorexia and alter family behavior [1-12]. Minuchin's work was highlighted by a strong therapeutic presence, specific attention to family behavior within therapeutic sessions, and the creation and assignment of tasks that would help change family relationships and establish control over the symptoms of the anorexia. Family therapy for anorexia, as described by Minuchin, was based on structural family therapy that he had originated and described [13,14]. Minuchin's therapeutic efforts for anorexia include (1) establishing parental hierarchy within the family, (2) clarifying and resolving conflict between parental figures, (3) establishing boundaries between family subsystems and between individual family members to reduce parental overinvolvement with the anorectic patient, and finally (4) involving the entire family to enhance the development of the young person with anorexia while she achieves autonomy appropriate for her age and developmental level. Liebman and colleagues, while working with Minuchin, amplified the techniques of family therapy for anorexia by integrating a behavioral

paradigm for weight gain within the family therapy [2,3,8,15]. Rosman [6] has described lunch sessions in which the anorectic patient and her family have a meal with the therapist. During these sessions, the cycle of family interaction concerning food is made apparent and directly altered.

Minuchin, Rosman, and colleagues also reviewed the treatment of a cohort of 53 patients with anorexia nervosa followed for at least five years after completion of family therapy for the anorexia. They found the treatment to be effective in inducing resolution of the anorectic symptoms and improvement in psychosocial functioning in 83% of the cases [4,5,7,9]. Sargent and colleagues have recently described the entire course of family therapy for anorexia including an outline of the integration of family treatment into hospitalization [16]. Sargent and Liebman have also recently reviewed a family-oriented approach to outpatient therapy [17] as well as family treatment for both anorexia and bulimia [18].

Other descriptions of family therapy for anorexia have included (1) a description of the role of hospitalization in catalyzing and supporting family therapy [19], (2) an elucidation of the family ties of loyalty across three generations in families of anorectic members, with specific interventions aimed at diluting and altering the impact of loyalty conflicts and trans-generational coalitions [20], and (3) Selvini-Palazzoli's work in identifying family patterns of control and the influence of the larger culture upon the family with an anorectic member at

times of transition [21]. A more strategic approach to family therapy has been advocated by Madanes in her description of marital therapy for a couple in which the woman was chronically bulimic [22]. Schwartz and colleagues have outlined an integration of structural and strategic techniques of family therapy for families with bulimic members in which positive connotation of the symptom and flexible participation in therapy sessions with fluctuating attention to bulimic symptoms and family interaction have been successful in reducing bulimic symptoms [23,24].

This chapter will describe the guiding concepts of family therapy for eating disorders and outline a family approach to the treatment of anorexia nervosa and bulimia. Specific interventions appropriate for the treatment of each of these disorders will be reviewed, and family therapy approaches to the problems particular to each disorder will be identified.

#### **A CONCEPTUAL FRAMEWORK FOR FAMILY THERAPY FOR EATING DISORDERS**

Family therapy as a set of psychotherapeutic techniques is based on a conceptualization of the family as a biopsychosocial system. Family systems theory becomes a way of understanding both a particular family and the symptoms that are presented for treatment. This conceptualization points out the role of family interaction in the maintenance of eating disorder symptoms and also identifies the role of these symptoms in maintaining family stability and integrity [4,5]. The behavior of the family member with the eating disorder affects other family members. Their behavior, in turn, affects the symptomatic identified patient. Dysfunctional family relationships and family interaction patterns apparent in families of patients with anorexia nervosa and bulimia have been described previously (Chapter 14). The therapist treating the eating disorder, therefore, should recognize that his role is to identify ways for the family to respond more effectively to the eating disorder symptoms, and to improve family relationships while facilitating the family's role in the growth and development of the individual with the eating disorder.

Several key concepts form the underpinnings of family treatment for eating disorders. The therapist's initial efforts are directed at reframing the eating disorder symptoms in relation to family interaction and not solely as the problems of a disturbed individual. As that belief takes hold within the family, the therapist can enhance family members' responsibility to react differently to the eating disorder symptoms and to relate to the individual with the eating disorder in a more productive manner. The eating disorder symptoms themselves

become communications within family interaction, and individuals are encouraged to communicate more directly verbally, without using the symptoms or predictable responses to them. The family therapist focuses on problems apparent in dyadic relationships as he or she identifies cross-generational coalitions in which a parent and child join together against the other parent or important adult. As these problems are highlighted, the therapist should reinforce supportive family relationships, thus creating productive communication between family members within the therapy sessions.

The family therapist appreciates the strong loyalty and interdependency in families with eating disorders and uses individual and family strengths to create alternative relationships between people. Individual autonomy is possible while a sense of mutual responsibility and interrelatedness are supported. The family therapist also enhances and reinforces family problem-solving and family development. This occurs especially in relationship to difficulties inherent in adolescent and young adult development. As the family therapist develops a holistic approach that unites the physical and psychosocial needs of the eating disordered individual, he will also be able to help the family balance individual and family needs. Finally, the family therapist, through his focus on disordered family interaction, will be able to recognize the vulnerability of all family members, appreciate each individual's pain and difficulty in his or her current situation, and assist the family to be more supportive for each individual throughout the course of treatment. The family therapist's focus on the present and the future can create an approach to therapy that is growth-oriented and that will transform the rigidity and resistance of the family, which views change and growth as particularly threatening and difficult.

#### **FAMILY TREATMENT FOR EATING DISORDERS**

##### **Medical Evaluation**

Any approach to an individual with an eating disorder and her family requires an evaluation of the individual's physical and psychosocial status as well as an understanding of the family's response to the symptoms and other important aspects of family interaction. Prior to the inception of family therapy, we strongly recommend that the individual with an eating disorder have a complete physical evaluation that identifies the appropriate diagnosis, current nutritional status, and any physical complications secondary to the symptoms of the eating disorder. The physical evaluation should be done on an outpatient basis if possible. Specific diagnostic concerns or the patient's physical status may warrant medical hospitalization. In our view, it is essential for

parental figures to participate in the medical evaluation with the young person with an eating disorder so that any questions concerning either the etiology, physical status, or recommended nutritional or medical treatment may be answered directly. In addition, the individual with the eating disorder experiences parental concern about the physical effects of her symptoms. This will also insure that the parents and the young person hear the same facts concerning the eating disorder, so there is little opportunity for further conflict concerning the physician's statements. The therapist also should understand the physician's impression of the patient's physical status and his recommendations for nutritional and medical treatment so that he/she can further reinforce the physician's statements through the initial phases of family therapy. The physician who performs the physical evaluation should understand the physical and metabolic symptoms associated with eating disorders and be able to make a straightforward statement to the family and patient concerning the patient's condition. It is important also that the physician not become embroiled with the patient in discussions or arguments about potential complications of the eating disorder or goals with respect to weight gain or weight maintenance. Frequently, the parents or involved adults will expect that the physician convince the patient of the correctness of his/her statements, which the physician must resist.

It is also essential for the physician and family therapist to coordinate their plan for monitoring the patient's weight, physical status, and body chemistries as directed by the nature of the patient's condition. This will enable the family to recognize that treatment is coordinated and enable the therapist to know the patient's physical status through the course of treatment. It is also important that the physician appreciate that the changes necessary for resolution of the eating disorder will be taking place in therapy sessions and that he or she will need to communicate directly with the therapist if he has concerns about lack of progress in treatment or about deterioration of the patient's physical condition. Effective collaboration between the physician and family therapist will lead to greater organization within the family as members respond to the individual with the eating disorder and to more control for the therapeutic team over the family's level of anxiety and motivation for change. Physician-therapist coordination requires frequent communication and clear identification of appropriate boundaries. The family therapist encourages the family and patient to take medical questions directly to the physician, and the physician encourages them to bring questions about the direction or efficacy of therapy to the therapist. Especially early in treatment, the family may identify frustration with or

confusion about the approach taken in family therapy and may bring this to the physician's attention. It is important that the physician encourage the family to direct their concerns and questions to the therapist for resolution.

The potential for confusion and splitting of the treatment team also exists when additional health professionals are involved with family members on a regular basis in the course of treatment. In some treatment programs, a nutritionist provides nutritional guidance and a nurse or nurse practitioner weighs the patient regularly. It is essential that these professionals coordinate their efforts with those of the physician and family therapist and also that all professionals develop an approach that is directed at the entire family and not purely at the individual with the eating disorder symptoms. It may be possible in some circumstances for the nutritionist or nurse practitioner to meet individually with the young person with the eating disorder; however, it is important that these meetings be goal-directed, informational in content, and encourage personal responsibility on the part of the patient and not act as substitutes for individual or family psychotherapy. These professionals need to frequently remind the patient to bring important issues up in therapy sessions.

The physician can also, at times, be of immeasurable assistance to the therapist if the family should discontinue psychotherapy prematurely. At that point, the therapist can inform the physician of this difficulty and encourage the physician to also discuss this decision with the family. He or she can inform the family of the risks that they are incurring by prematurely discontinuing treatment, and strongly advise them to continue therapy. If the physician determines that the family is displeased with therapy or mistrusting of the therapist, he/she can help the family outline their concerns and questions and support the family in bringing these questions directly to the therapist for resolution. Often the support of the physician, another trusted professional, or an individual within the family's community enables a family to persevere with therapy to resolution of symptoms and improvement of family relationships.

#### **Individual and Family Assessment**

Strober has described the heterogeneity of patients with anorexia nervosa [25]. Descriptions of individuals with bulimic symptoms also highlighted the varieties of psychosocial adaptation, impulse control, and symptom frequency in large groups of patients [26,27]. It has been our impression that there is also marked heterogeneity in family interaction, with many families demonstrating markedly more functional interaction and relationships and being more responsive to therapeutic interventions. Therefore, an assessment of individual and family psy-

chosocial functioning at the inception of treatment is essential for planning therapeutic interventions and to determine prognosis.

The assessment of the patient with anorexia or bulimia includes an evaluation of impulsivity and self-care by identifying the level of eating disorder symptoms, as well as noting the patient's ability to take an independent position verbally by stating her goals concerning eating and weight control. Her independent academic, occupational, and social adaptation help form a picture of her development, extrafamilial success, and her self-esteem. The young person's ability to relate to both the therapist and family members during the initial family interview is also identified. The therapist pays particular attention to the patient's ability to relate, to speak in an assertive and goal-directed fashion, to project herself into the future, to recognize and experience both success and failure, and to cope effectively with disappointments and emotional upset. The patient's openness and her ability to disagree and state her own position directly are also important. Her ability to reason abstractly can be identified through noting her understanding of the positive and negative consequences of the eating disorder symptoms and her goals for treatment. The degree of denial and difficulty entering trusting relationships can also be determined by the therapist through direct questioning and through observation of family interaction. It is our impression that relating ability and degree of impulse control are among the most important individual psychosocial features of the patient in determining prognosis. The therapist will need to be attentive to clues about these qualities throughout the initial evaluation phase.

The therapist, in evaluating the family, will attend especially to the availability of individual family members for a relationship with the therapist and their personal flexibility as they approach treatment. The therapist also monitors relationships within the family and carefully notes both intrusiveness and abandonment between family members, especially as problems are discussed or need to be resolved. It is our impression that the psychological availability of family members to participate in treatment and their ability to take responsibility for the therapeutic process—together with the therapist—have most prognostic significance for successful resolution of the eating disorder. If parents are totally focused on their own individual efforts with the patient and her symptoms and not able to maintain a stable relationship with the therapist in the early phases of family therapy, then treatment is likely to be more difficult and require greater intensity on the part of the family therapist.

It is also extremely important for the therapist to

identify difficulties with impulse control for the parents. Impulse control problems may involve substance abuse, poor frustration tolerance, or explosive responses to conflict or disagreement. The more impulsive family members are, the less flexible their relationships are, and the less available they are to assist the eating disordered individual.

Finally, it is important for the therapist to pay attention to family members' appreciation of the effectiveness of their efforts. In eating disordered families, individuals often care more about the perceived correctness of their actions and less about whether the actions are effective. This can lead to significant defensiveness on family members' parts and relationships that are characterized by repeated criticisms and attacks. There is a marked lack of mutuality within these relationships, which then leads to an inability of people to support one another, especially when distressed. The degree to which there is a lack of mutuality and inflexibility in family relationships will also need to be defined and altered during the course of treatment. Finally, the structure of the family, including who takes a leadership position, how effectively parents encourage mature behavior on the part of their children, and the level of power of the symptomatic member, will also need to be examined. If family relationships are continually defined by marked disrespect and a significant lack of cooperation between the parents, often the symptomatic individual is involved in an intense relationship with one parent to the exclusion of the other parent. Treatment will also need to define and address these difficulties while providing more autonomy for the symptomatic individual and creating more satisfying relationships for the parents both together and separately.

### **The Family in the Hospital**

The use of the hospital for the treatment of symptoms related to anorexia nervosa and bulimia has been described at length elsewhere in this volume. (See Chapters 19,22,37,38) It is our strong impression that hospitalization should be identified to the family as an intervention with potential helpful effects not only for the eating disordered individual, but for the family as a whole. We create this orientation by helping the family to see hospitalization not as a sign of their failure and need to relinquish responsibility for the patient, but rather as an opportunity for the family as a whole to gain new skills and learn new ways of responding to the symptoms and supporting the patient's recovery. We promote this effort by requiring that the entire family participate in the initial assessment prior to hospitalization and that the family, as a whole, identify goals that are to be achieved during the hospitalization both for the in-

dividual and for her family. Hospitalizations are short-term (30 to 40 days) and the family is actively involved in the hospital program. Thus, the family as well as the staff develop methods of responding to the eating disorder symptoms and psychosocial difficulties. In our experience, 15% of patients with anorexia or bulimia require hospitalization.

Medical hospitalization in our program is used to rectify severe nutritional deficiencies and metabolic difficulties. Once patients are medically stable, they are transferred to our family-oriented psychiatric inpatient unit. The psychiatric hospitalization is directed toward creating a sense of momentum and participation in the treatment of the entire family as well as an appreciation of the role of family change in resolving the eating disorder. The hospital staff enlist the parents into the treatment team at the same time as the hospitalized individual is encouraged to participate in defining her own program. The parents and staff together take responsibility for identifying appropriate and effective behavioral responses to eating disorder symptoms. A program emphasizing weight gain for anorectic patients and a contract to ensure monitoring to prevent purging for bulimic individuals is chosen for a particular family and patient because it is successful. Renegotiation of the treatment contract is possible. Family therapy sessions through the course of hospitalization are essential to define the most appropriate method of using the hospital successfully.

The patient is strongly supported to obtain autonomy by demonstrating physical and psychological responsibility for herself. She is encouraged to define her own needs with the help of the peer group within the hospital and the hospital staff in order to present her wishes to her family in an assertive and forthright fashion. The hospital environment also can provide a sense of control for the entire family, thereby reducing everyone's anxiety. At the same time, it can help people develop new forms of relating to one another. By reducing family anxiety, impatience, perfectionism, and impulsivity also can be diminished and treatment can proceed in a patient, measured fashion oriented to developmental change for the patient and her family. The father may participate with his daughter in some hospital activities, while the mother participates in others. The father and mother together may be encouraged, during the daughter's hospitalization, to do different things together as they begin to resolve differences concerning their own relationship as well as concerning the eating disorder.

Discharge from the hospital is contingent upon the achievement of individual and family psychosocial goals as well as on the achievement of weight gain and improvement in symptoms. If the hospitalization has been

successful, there will have been an introduction of greater interpersonal flexibility among family members as well as greater autonomy for individuals. Family members also should have a greater sense of mutual support and mutual understanding. If the outpatient therapist is able to be actively involved in treatment during the hospitalization, the hospitalization can enhance his/her relationship with the patient and her family and build the level of trust and support between family and outpatient therapist. This involvement can also further the working relationship of the family and therapist for future outpatient therapy.

We have found that in extremely difficult situations, multiple hospitalizations may be necessary; however, it is important that each hospitalization be identified as a positive step to resolve limited, important difficulties in treatment at the present time. By involving the entire family in the course of hospitalization, we attempt to decrease the parents' sense of helplessness and family dependency upon the hospital when things are difficult. In addition, we enhance the entire family's appreciation of responsibility for resolution of the eating disorder symptoms. The patient's age and developmental status are important in outlining the course of treatment as well as highlighting the goals of a hospitalization and the responsibility of family members. The younger the patient is both chronologically and developmentally, the more the parents will need to be involved in a way that emphasizes their responsibility for their daughter's symptoms. On the other hand, developmentally older patients who are more autonomous require parental involvement that is collaborative and supportive rather than controlling. Therapist and hospital staff need to be highly flexible in their understanding of individual situations and assist parents to react in ways that support the young person's experience of control and developmental gains. This may be extremely difficult, because the parents' attempts to control the young person and her symptoms reflects not only their sense of their child's ineffectiveness, but also the parents' own need to be actively involved with her and their need to reduce their own anxiety as they experience her difficulties.

#### **Outpatient Treatment of Anorexia Nervosa**

The family therapist carries out outpatient therapy for anorexia with assurance of the patient's physical stability, an impression of the physiological and psychosocial status of the identified patient, and an appreciation of the family's style of interacting and of responding to the eating disorder symptoms. The initial phase of treatment, whether hospitalization is required or not, is a phase in which clear and defined responses to weight-related symptoms are identified and in which the therapist creates strong relationships between him or herself

and all family members. In so doing, the therapist alters the family's experience by requiring that they attend to his/her expectations as well as their own preferred responses to difficult situations. The therapist also identifies each family member's strengths and competencies and develops a relationship with each of them based on mutual respect and consideration. A transformation of the family takes place based on the therapist's presence and input. The therapist then gains initial control over the therapeutic process and begins to define, with the family, problems to be solved and to create shared approaches to these problems. The therapist maintains a holistic approach to treatment by retaining the dual goals of greater interpersonal space and further differentiation and more effective and satisfying support and mutual connectedness.

A consistent, nonimpulsive response to eating and weight can be identified early on and maintained throughout the course of treatment. For significantly low-weight individuals, steady, slow (1 to 2 lb per week) weight gain can be reinforced on a regular basis while parents are advised to leave to the young person the problem of determining what to eat in order to meet the weight-related goals. If the anorectic individual claims helplessness and ineffectiveness as the cause of poor weight gain, then she can be encouraged to ask her parents and other potential support people for assistance in defining the food intake necessary to gain the required weight. The therapist guides the parents to help the young person with anorexia to recognize her responsibility for meeting weight goals while helping the parents to limit their intrusiveness and ineffective attempts to control food intake. Potential parental responses to lack of weight gain should be agreed upon and consistently enforced. These responses should limit the eating disordered individual while the parents are encouraged not to become involved with her disappointment at experiencing these consequences of failure to gain weight. Such responses as a limitation of exercise or activities or an inability to participate in a desired event may be stipulated as consequences. It is important, though, that the parents experience the primary responsibility to reinforce her success. The therapist constantly attends to this process of building interpersonal boundaries and personal autonomy. Helplessness is transformed into competence and enmeshment into individuation. The parents are helped to recognize that the young person will need to gain weight and become more mature for herself, while the parents are encouraged to identify goals for themselves as individuals and for their relationship instead of relying solely on their daughter's improvement to enhance their self-esteem.

As treatment proceeds, the therapist identifies further issues for the therapeutic agenda, including psychosocial goals for the patient such as increased flexibility, greater patience, more effective friendships, and potential for intimacy. The parents' individual concerns about job, personal success, growing older, and adjusting to the increasing maturity of their children as well as marital dissatisfaction also become issues for therapy.

As these items are added to the treatment agenda, the therapist creates an experience of continuity for the treatment and remains its guiding force until the family as a whole trusts both the therapist and the changes that are slowly taking place in treatment. It is not unusual for families with anorexia to return for treatment on a weekly basis for several months, acting in the beginning of each therapy session as though they were just beginning treatment, having not understood or experienced previous sessions. The therapist must be patient and appreciate that this rigidity is a reflection of the family's anxiety, pre-existing resentments, their concern that effective change is not possible, and their fear that treatment will be significantly disruptive to the family. As the therapist maintains a sense of patience, continuity, and support, as well as a sense of humor and a sense of optimism about the possibilities of all family members for the future, the family increasingly comes to experience therapy as a welcomed and desired situation and see that change and growth are valuable for all of them. Therapists make two common errors with families with anorectic members: first, the therapist maintains a stance of impatience and criticism of the family if the therapist thinks they are responding too slowly to treatment; and second, the therapist develops too much closeness to one family member, creating isolation from other family members and often not believing in their ability to change. The therapist must be able to develop a respectful relationship with each family member and then help build family relationships. The therapist can share the responsibility for the course and pacing of treatment with the family by expecting them to identify issues for resolution and to demonstrate greater flexibility and more mutual concern.

The therapist also addresses the quality of the anorectic individual's relationship with each of her parents and helps her develop effective but different relationships with her father and with her mother. These relationships should be based on mutual respect, with opportunities for individual assertiveness and clear communication on the part of parent and young person. The father often is demanding and impatient. First the therapist and then the anorectic patient will need to challenge this. The therapist can help her expect that he be supportive of her and recognize both her abilities and

her inabilities. The patient and her mother also will need to learn to cooperate more effectively with one another and become truly connected in a less competitive and critical fashion. This often requires that the mother recognize her inability to totally protect her daughter from hardship and her need to be available to her daughter when distressed, but in a genuinely calm and supportive fashion. As the therapist works on the anorectic patient's relationship with each parent, it is important that he or she help the other parent to support that process and not find increasing closeness between his or her daughter and spouse threatening. This often depends on the development of a more respectful and less antagonistic and resentful relationship between the parents, which the therapist is encouraging throughout the course of treatment.

As treatment progresses and there is greater differentiation of individuals and enhanced mutual respect within the family, sessions should be planned to include appropriate family members according to the issues worked on at that time. At times, individual sessions for the patient or sessions for both parents may be necessary, and sessions that involve father and daughter or mother and daughter may be appropriate. We generally recommend that one outpatient therapist continue the treatment and work with smaller subgroupings as well as with the entire family. This is often very helpful, because the therapist then not only works with the family members present at a particular session, but also creates ways in which his work with those individuals further facilitates his and the family's overall goals for treatment.

Anorexia occurs in families of varied composition and with varied levels of flexibility. Problems occur in treatment based on the history of the family, the chronicity of the symptoms, and previous ineffective treatment. In situations where the anorectic's parents have separated or divorced prior to the inception of treatment, we believe that it is essential that both natural parents be involved in therapy as well as other important family members. This may require sessions that include both natural parents without the young person to establish methods of effective collaboration and consistent approaches to the eating disorder symptoms. In remarried families step-parents should also be involved so that all adults are collaborating in an appropriate way. The therapist generally has the ability to bring important family members into the treatment process early in treatment based on concern for the young person's safety and for the severity of the symptoms. In some situations, significant resentment may exist between ex-spouses, and the therapist will need to be forceful in arranging that both natural parents collaborate effectively in limiting their disagreements and developing a unified

approach to treatment.

In situations where chronicity and treatment failure have led to marked helplessness on the part of all family members, it is often helpful for the therapist to begin with a somewhat detached, inquisitive approach, letting the family know that this treatment will only be effective if it includes all members in an active way. The therapist can define everyone's participation in ways that are different from previous treatments and, thus, avoid previous pitfalls. It is common for families who have been faced with chronic symptoms to hope that the next treatment will be effective and also to be impatient and impulsive in their approach to the therapeutic process. In these situations, a systemic approach using the techniques of Selvini-Palazzoli and colleagues [28] is often very helpful in appreciating the nature of family interconnectedness and in identifying reasons for previous treatment failure. As the therapist resists the family's attempt to get him/her to take full responsibility for the patient's recovery, he or she then will have the authority to move the family's participation in the desired fashion. The therapist's approach should be genuinely friendly, interested, and humane while also remaining questioning of the family's ability to actively collaborate in a different way with treatment. He should convey his belief that recovery is possible, but it is a choice which the entire family must make.

Termination of treatment can occur at different times for different family subsystems. We generally hold follow-up sessions monthly with the patient and with the family for two to four months when the patient, spouses, and entire family are functioning effectively. We may maintain phone contact with patient and family for some time after that. We try to help family members to experience their own resources in dealing with stresses and transitions. We move to decrease our therapeutic involvement as these stresses are negotiated by family members with little disruption in other family members or subsystems.

#### **Outpatient Treatment of Bulimia**

Much of outpatient psychotherapy for bulimia will be similar to treatment for anorexia nervosa. The therapist will identify family relationships and determine when the symptoms occur, what events precipitate binges, and the role of family members in bringing on episodes of bingeing and purging. Difficulties in treatment can arise due to the lack of objective markers of symptomatic behavior. The therapist will need to define with the family and patient appropriate medical surveillance, depending upon the degree of purging, which limits the acute risks of purging behavior. This medical monitoring can take place on a weekly or biweekly basis and provide a sense of safety for the patient and her family. Monitor-

ing can be reduced as the patient demonstrates reduced impulsivity and greater control over symptoms. A treatment plan is developed that identifies the need for all family members to collaborate in the resolution of the symptoms and identifies alternative means for the patient to respond to the stress and emotional upset that have led to episodes of bingeing and purging. The patient often expresses a desire to work on resolving the symptoms independently without her parents. The therapist resists this as he supports family collaboration in resolution of the bulimia. The therapist will need to identify positive features of the symptoms for the patient and her family and help them determine ways of establishing and encouraging alternative methods of satisfaction and release of tension. Together the family and the therapist will help the patient to eat when she is physically hungry and manage her diet appropriately to reduce episodes of weight gain and periods of anxiety leading to purging behavior. The therapist may suggest collecting data concerning the symptoms (ie, a record containing what the patient eats and what she is feeling and doing when she eats) before helping the family reduce the symptomatic behavior. The parents are instructed not to attempt to interfere with the symptoms during this time. Restraining the family from changing rapidly reduces everyone's anxiety that the symptoms will be gone without positive change in family behavior and family relationships [24]. Throughout the treatment of bulimia, the therapist actively encourages individuation and independent control as he encourages parents to establish a foundation of self-acceptance and appropriate response to food and weight for the patient. Patient and family members learn to express and resolve conflict while the parents learn to provide genuine support to the patient. Other difficulties with impulse control are addressed directly in treatment.

The major problems in the treatment of bulimia include abrupt cessation of symptoms, leading to premature termination of treatment, and the tendency of family members to become frustrated if symptom resolution does not occur rapidly. The therapist will reinforce the family's participation in a gradual process of resolving the symptoms of bulimia and encouraging appropriate support within the family as well as differentiation and development for both patient and parents. As in the treatment of anorexia, therapy proceeds from family sessions to individual therapy for the patient and marital therapy for the parents. The development of themes and issues to be pursued occurs as described above. Antidepressant medication, relaxation training, group therapy, and self-help groups may assist the patient significantly in dealing with depressed affect and anxiety and decrease loneliness and social isolation,

which lead to repetitive episodes of bingeing and purging. We feel strongly, however, that these treatment modalities should be used only when patient and family are actively engaged in the therapeutic process. Any additional treatment modalities should also help family members, through the therapist's support, to provide increased support for one another and assist the patient to develop friendships and effective social relationships, and to improve self-esteem and contentment with herself.

Family therapy for bulimia should continually recognize and support the patient's degree of autonomy and her increasing psychological and physical self-control. This can be carried out in individual and family therapy sessions. However, the therapist must also recognize the importance of effective family relationships for the patient and steadily counteract family members' tendency to abandon the patient and be unavailable to her when she is stressed and in need of support.

## CONCLUSION

Family therapy addresses the individual and family difficulties associated with eating disorders. It provides assistance that balances need for autonomy and need for supportive relationships through changes in family interactions. Family treatment offers hope that the patient can be independent, competent, and self-satisfied, and that her family can respond to the eating disorder successfully. The therapist is an active catalyst of treatment and is responsible for the quality of her relationship with all family members. His or her concern for the patient and her family should be addressed directly and humanely. With patience and persistence—and with thoughtful planning and a clear conceptualization of the role of family interaction in the maintenance of the eating disorder symptoms—the family therapist can help the family support individual and collective development and effectiveness.

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