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The empirical and theoretical base of family therapy and multiple family day therapy for adolescent anorexia nervosa

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There is growing empirical evidence that family therapy is an effective treatment for anorexia nervosa, particularly in adolescence. This is in spite of the fact that the theoretical model from which most of the empirically based treatments are derived appears flawed. This paper provides a brief overview of the research evidence from treatment studies and studies of family functioning. It suggests that the main limitation of earlier theoretical models is their focus on aetiology rather than on an understanding of how families become organized around a potentially life-threatening problem. An alternative conceptual model is presented, and its application to family therapy and multiple-family therapy for adolescent anorexia nervosa is described. The treatment approach focuses on enhancing the families' own adaptive mechanism and mobilizing family strengths.

Introduction

Models of psychotherapy evolve in complex ways but central to most models is usually an explanatory model of a disorder which aims to explain its development and maintenance. An explanatory model for a particular disorder often becomes a paradigm for a particular approach to psychotherapy (e.g. hysteria for psychoanalysis, phobias for behaviour therapy, or depression for cognitive behaviour therapy). The obvious paradigm disorder for family therapy has been schizophrenia with Bateson's theory of the double-bind which played a major role in shaping the theory and practice of family therapy. One of the other major paradigms for family therapy is Minuchin's conceptualization of the psychosomatic family (Minuchin *et al*., 1978) which has not only had a major impact on the treatment of anorexia nervosa but has also played an important role in the development of family therapy, particularly structural family therapy.

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Such paradigm models are important partly because of the potential insights they may provide for the understanding of a particular disorder but perhaps more importantly because they give us (at least implicitly) the main building blocks for the model of change that underpins the therapeutic approach. If one accepts the 'psychosomatic family' paradigm as accurate, there are direct implications for treatment, the aim of which is to 'normalize' the psychosomatic family. For instance, Sargent *et al*. (1985, p. 278) conclude their account of the family therapy for anorexia nervosa thus:

> The syndrome of anorexia nervosa is associated with characteristic dysfunctional patterns of family interaction. The family therapist conceptualizes anorexia nervosa in relation to the organization and functioning of the entire family . . . and plans the therapeutic interventions to induce change in the family.

The link between explanatory models of disorders and treatment is, however, more tenuous then is sometimes assumed. First of all, even if a model provides an accurate account of the origins of a problem it does not necessarily tell us how best to treat it. For example, there is a considerable body of research on the biological factors that may be contributing to the development of anorexia nervosa (Connan and Stanley, 2003); yet pharmacological treatments are of very limited benefit (Treasure and Schmidt, 2002). By the same token a treatment derived from a particular explanatory model may be effective, even though the model itself may be shown to be wrong. Indeed in the history of psychotherapy (and more broadly of psychiatry and to a considerable degree of medicine generally) this is a very common scenario and, as I will try to demonstrate below, applies also to the psychosomatic family model.

Most explanatory models from which different treatments are derived have a much more limited shelf-life than the treatments themselves, and we should not be surprised to find that empirical support for the psychosomatic family model is unconvincing. What is perhaps more surprising is the tenacity of the model to continue to survive in the face of the mounting empirical evidence against it. Many would argue that this is because clinicians ignore research findings either through ignorance or through natural scepticism. Although there may be some truth in this I suspect that the more important reason is the lack of alternative conceptualizations of how (structural) family therapy brings about change. The aim of this paper is to offer if not a comprehensive theory then at least some useful

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building blocks for such a project. Before doing this, two brief diversions may be useful: first, an overview of the evidence for the effectiveness of family therapy in eating disorders, and second, a discussion of what studies of family functioning tell us about the nature of eating disorders (and crucially what they do not tell us).

Evidence for the effectiveness of family therapy for eating disorders

Since Minuchin and his colleagues at the Philadelphia Child Guidance Clinic (Minuchin *et al*., 1975, 1978) published the first family therapy follow-up study in anorexia nervosa, a number of other studies have been reported which have largely confirmed their findings albeit with a number of caveats. Table 1 summarizes the results from the various family intervention studies in anorexia nervosa.

The clearest and most consistent findings come from the evaluation of treatments for adolescents. As was shown by Minuchin, adolescents suffering from anorexia nervosa generally do well when the main treatment is family therapy, often without the need for inpatient treatment. By the end of treatment between half and two-thirds will have reached a healthy weight, although most will not yet have started menstruating again. By the time of follow-up between 60 to 90% will have fully recovered and no more than 10 to 15% will still be seriously ill. A striking aspect of these studies is the low rates of relapse after successful treatment particularly when compared to inpatient treatment, where 25 to 30% relapse rates are typically reported after first admission, rising to 55 to 75% for second and further admissions (Steinhausen *et al*., 1993; Strober *et al*., 1997; Lay *et al*., 2002). On the basis of the evidence from these studies several reviewers (e.g. Wilson and Fairburn, 1998; Carr, 2000) have concluded that family therapy is the treatment of choice for adolescent anorexia nervosa. This is also reflected in the recommendations in the recently published treatment guidelines for eating disorders from the National Institute of Clinical Excellence in the UK that: 'Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa (B)[1]' (NICE, 2004, p. 65).

There are three main caveats to these conclusions. First, the studies published to date are all relatively small and a number of them have

[1] Level B recommendations are those that are based on well-conducted clinical studies in the absence of sufficiently robust randomized clinical trials which are needed to classify the recommendations at level A.

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TABLE 1 *Studies of family therapy for adolescent anorexia nervosa*

	Sample	Treatments	End-of-treatment results	Follow-up results
		Open follow-up studies		
Minuchin *et al*., 1978	N = 53 Age = 14.8 years Duration = 8.6 months	Average of 6.8 months FT 57% admitted for a mean of 2.4 weeks	not reported	FU 2.7 years recovered 86%; fair 4%; unimproved or relapsed 10%
Dare, 1983	N = 12 Age = 14.7 Duration = 11.6 months	Outpatient treatment only FT for mean of 6 months	not reported	FU 0.85 year 33% recovered; 58% fair; 8% unchanged
Martin, 1985	N = 25 Age = 14.9 years Duration = 8.1 months	Average of 11 months FT 72% admitted for mean of 8 weeks	23% good; 45% intermediate; 32% poor	FU 5.1 years 80% good; 4% intermediate; 16% poor
Stierlin and Weber, 1987 Stierlin and Weber, 1989	N = 42 Age = 18.2 Duration = 3.3 years	Outpatient treatment only Average of 8.7 months FT	17% good; 4% intermediate; 79% poor	FU 4.4 years; 60% good; 40% poor
Mayer, 1994	N = 11 Age = 17 years Duration = 9 months	Outpatient treatment only FT for 1-9 months.	not reported	Mean FU 1.7 years 57% good 29% intermediate; 14%poor
Herscovici and Bay, 1996	N = 30 Age = 14.7 years Duration = 10.3 months	FT for 24 months 43% admitted for mean of 4 weeks	not reported	FU 6.1 years 60% good; 30% intermediate; 10% poor

Continued

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TABLE 1 *(Continued)*

	Sample	Treatments	End-of-treatment results	Follow-up results
		Randomized treatment trials		
Russel *et al*., 1987 Eisler *et al*., 1997	N = 21 Age = 15.3 years Duration = 14.4 months	10.3 weeks inpatient + 1 year FU of:(a) family therapy (b) individual supportive therapy	(a) 60% good; 30% intermediate; 10% poor (b) 9% good; 9% intermediate; 10% poor	FU 6.3 years (3.1–9.8) (a) 90% good; 10% poor (b) 36% good; 18% inter; 46% poor
Le Grange *et al*., 1992 Squire-Dehouck, 1993	N = 18 Age = 15.3 years Duration = 13.7 months	6 months outpatient FT: (a) conjoint family therapy (b) separated family therapy	(a) 20% good; 50% intermediate; 30% poor (b) 50% good; 40% intermediate; 10% poor	FU 2 years (a) 33% good; 33% intermediate; 33% poor (b) 87% good; 13% intermediate
Robin *et al*., 1999	N = 37 Age = 14.2 years Duration <12 months	1–1.5 years FT/IT (43% admitted): (a) behavioural family systems therapy (b) ego-oriented individual therapy	(a) 59% good; 6% intermediate; 35% poor (b) 38% good 31% intermediate 31% poor	FU 1 year (a) 73% good; 7% intermediate; 20% poor (b) 64% good; 29% intermediate; 7% poor
Eisler *et al*., 2000 Eisler *et al*., submitted	N = 40 Age = 15.5 years Duration = 12.9 years	1 year FT (10% admitted): (a) conjoint family therapy (b) separated family therapy	(a) 26% good; 21% intermediate; 53% poor (b) 48% good; 28% intermediate; 24% poor	FU 5 years (a) 61% good; 17% intermediate; 22% poor (b) 76% good; 19% intermediate; 5% poor
Ball and Mitchell, 2004	N = 25 Age = 18.1 Duration = 18 months	1 year CBT/BFT (16% admitted) (a) behavioural family therapy (b) cognitive behavioural therapy	(a) good/intermediate 78%; poor 22% (b) good/intermediate 78%; poor 22%	FU 6 months (a) good/intermediate 78%; poor 22% (b) good/intermediate 78%; poor 22%

methodological limitations, and therefore a degree of caution is needed in interpreting the findings. Second, it is important to recognize that there has been hardly any research comparing family therapy with other treatments. Cognitive or psychodynamic treatments are described in the literature (Bowers *et al*., 1996; Jeammet and Chabert, 1998) and are often used in clinical practice, but, with the exception of the small study by Ball and Mitchell (2004), they have not been systematically evaluated with adolescent anorexia nervosa and their relative merits in comparison with family therapy are not known. The third caveat concerns the fact that nearly all the studies quoted above are of family therapy with a strong 'structural flavour' (i.e. they all emphasize the importance of helping the parents to have a strong instrumental role in opposing the anorexia – of which more below). The family therapy literature contains a host of accounts of using family therapy for the treatment of eating disorders drawing on a variety of other theoretical orientations including Milan Systemic (Selvini-Palazzoli, 1974), strategic (Madanes, 1981), feminist (Luepnitz, 1988; Schwartz and Barrett, 1988), attachment (Dallos, 2004) solution-focused (Jacob 2001) and most notably in recent years narrative (White, 1989; Madigan and Goldner, 1998). Other than Stierlin and Weber's (1987) follow-up study of a Milan-oriented treatment, there is no systematic evaluation and there are no direct comparisons of these different approaches.

Studies involving adults with anorexia nervosa provide a less clear picture. This is, at least in part, because the research to date has been done mainly with quite chronically ill patients for whom none of the treatments that have been evaluated have been startlingly successful. There is some evidence that specialist treatments (including family therapy but also psychodynamic psychotherapy and cognitive analytic therapy) are more effective than routine treatment (Dare *et al*., 2001) and family therapy may be slightly more effective than individual psychotherapies in reducing the risk of relapse following inpatient treatment (Eisler *et al*., submitted), but overall the most that one can say with confidence is that family therapy has a role to play in the treatment of adults with anorexia nervosa. However, the unknowns by far outweigh the knowns for this group.

Studies of family functioning and eating disorders

There is currently a considerable body of research on family functioning in eating disorders. The findings do not provide a very straight-

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forward picture and are not easily summarized in the brief space that can be devoted to this here. I will therefore highlight some general issues and illustrate these with some findings rather than attempt a comprehensive review. The largest group of studies have used self-report instruments such as the FES (Moos and Moos, 1981), FAD (Epstein *et al*., 1978) or FACES (Olson *et al*., 1979). Typically, comparisons of clinical and control groups show poorer functioning (e.g. in terms of communication or affective responsiveness) (Waller *et al*., 1989; Steiger *et al*., 1991). Community-based studies (e.g. Råstam and Gillberg, 1991) or studies of student-based samples (McNamara and Loveman, 1990), however, find much smaller (if any) differences and, when factors such as depression are controlled for, the differences tend to all but disappear (Blouin *et al*., 1990). One of the more consistent findings (though not always highlighted by the authors themselves) is that families with an anorexic child are more like control families than they are compared to other groups (cf. Scholz *et al*., 2005 in this issue) (for a detailed review see Eisler (1995), or for a more recent briefer review, Vandereycken (2002).

Observational studies (e.g. Humphrey, 1989; Kog and Vandereycken, 1989; Røijen, 1992) come closest to a direct test of the psychosomatic family model but, like the self-report studies, do not provide sufficiently clear evidence to support the model. A good example is the study by Røijen (1992) who researched a group of families with an anorexic child using the Beavers scales of family assessment (Beavers, 1982) to rate family interaction during a standard task. He found three distinct interactional styles: a close, enmeshed style, a disorganized style and a mixed style, the three styles being described as 'centripetal', 'centrifugal families' and 'well functioning'. When the families were rated on how well they were functioning, just over 20% were rated as being moderately or severely dysfunctional and most of these were in the 'centrifugal' group. While this is a small study and only limited conclusions may be drawn from it, it is consistent with many other studies.

The general picture that emerges then is that there is no consistent pattern of family structure or family functioning in families where someone suffers from anorexia nervosa. What differences are found vary between studies and are often small and do not clearly define the family functioning in these families. They certainly do not add up to a picture of there being a particular type of family organization that is invariably found in anorexia nervosa. The lack of evidence in support of the psychosomatic family model is unlikely to convince everyone,

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and many researchers will undoubtedly continue to search for the elusive family factor that will explain anorexia nervosa. The real problem, however, is not in the difficult-to-pin-down family factors but rather that the design of most studies is such that they cannot really test the psychosomatic family model. Many studies having found an association between family factors and eating disorder make an unwarranted leap and conclude that this supports/confirms the theory. They then draw an even more problematic conclusion that this has important clinical implications. I will try to unravel both points.

For example, studies using the measure Expressed Emotion (Leff and Vaughn, 1985) show that families with an anorexic child are relatively non-critical (Le Grange *et al*., 1992; Hodes *et al*., 1999) in comparison with families with someone with schizophrenia (although they appear similar to families with a child with conduct disorder and are, if anything, higher in the amount of criticism than families with a child with an emotional disorder or control families – Vostanis *et al*., 1992). This, combined with findings from Kog and Vanderycken (1989) of the relative avoidance of open disagreement in comparison with controls, provides some support for one aspect of the psychosomatic family model, namely conflict avoidance. However, there are several possible explanations for the apparent association between low levels of criticism or conflict avoidance and anorexia nervosa (and the findings are equivocal) which may or may not include a causal connection but all of which fall short of explaining the presence of anorexia nervosa. For instance, it may be that families faced with a life-threatening condition like anorexia nervosa will tend to avoid conflict regardless of whether or not they tended to do that prior to the onset of anorexia. Another possibility may be that both conflict avoidance and eating disorder may be associated with a third factor and the association between the two is incidental. For example, starvation is strongly associated with depression, and those who are depressed may also be more likely to avoid conflict. Conflict avoidance in the family may of course be a contributory factor in the development or maintenance of an eating disorder in that it may be more difficult for the family to challenge the dangerousness of self-starvation in their daughter.

For many readers this will be a familiar line of argument which primarily highlights the limitations of cross-sectional studies (the most common type of study in family research). However, there is a more serious problem. Let us assume that a well-designed longitudinal study had shown that families in which someone eventually developed

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anorexia were more likely to have an interactional style in which conflict was avoided compared to other groups of families. While this would be evidence for conflict avoidance being a possible risk factor for the development of anorexia, it would still tell us little about why anorexia might develop in such a family. The reason for this is that the role of conflict avoidance as conceptualized by Minuchin can only be understood when it is put together with the other features of the psychosomatic family model: the strong sense of loyalty that makes disagreements feel like an act of betrayal, the strong focus in the family on bodily functions, the strong child orientation in which parental concerns are oriented to protect the child and her psychobiological needs in a way that leads to her becoming increasingly concerned with herself and her actions. The child in such a family is, according to Minuchin, unable to respond to the concerns and control over her psychological functioning directly because disagreement and overt conflict are unacceptable in the family. The self-starvation becomes her way of expressing the internalized preoccupation with herself and an attempt to gain some control. This both leads to greater pressure and disagreement in the family and at the same time takes on a central role in diffusing or mediating conflict.

In the context of the full account of the family dynamics described by Minuchin, conflict avoidance becomes a very understandable component of the process underlying the development of anorexia nervosa. What makes Minuchin's account so persuasive for the clinician is that the seemingly impossible to understand behaviour begins to make sense to the observer. The difficulty, however, arises when the clinical account of what may well be an accurate description of the family dynamics in some families with an anorexic child is generalized to become the *explanatory model of anorexia nervosa*. If the model is valid, then the above dynamic is presumed always to be present in some form. To confirm the validity of the model would require that *all* the components of the model are present in *all* the families. The model might be able to accommodate a degree of variability (e.g. having either conflict avoidance or lack of conflict resolution) but the more such accommodations are made the more the explanatory power of the model is diluted and the notion that what is being described is a general mechanism explaining the presence of anorexia becomes more and more tenuous.

A number of authors have argued recently (e.g. Treasure and Schmidt, submitted) that explanatory models which focus primarily on aetiology are less likely to be useful in guiding treatment than

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models of maintenance of symptoms. Family systems accounts of anorexia nervosa have tended to blur this distinction by implying that the factors which led to the development of the disorder are still operating and are in effect also maintaining the problem. This lack of differentiation has directed the focus of research virtually entirely to the question of 'what is the nature of families with anorexia'. The fact that this research has at best shown that certain family features may be associated with anorexia nervosa but do not provide an explanation of its origin means that it is difficult to argue that such features should be targets for clinical intervention. If the questions of aetiology and maintenance are separated, other types of questions about family functioning arise which are more relevant from a treatment point of view (e.g. are there differences between families of those who recover rapidly and those who remain ill for a long time; what family features help or hinder the therapeutic process; do different types of family respond better to different types of treatment).

Before moving on to the next section it might be useful to summarize the argument so far. I have argued that the family therapy for anorexia nervosa has been strongly influenced by theoretical accounts of family processes which imply that eating disorders are best understood as arising out of such processes. There is persuasive evidence that the treatments derived from these theoretical models are effective, certainly for adolescents and to a lesser degree possibly also for adults. I have tried to show on the other hand that the empirical evidence from research on family functioning does not support the theoretical explanatory models because (1) there are no consistent findings pointing to specific family features being associated with eating disorders, and (2) whatever connections have been found in particular studies show at best that there may be an association between, for example, low levels of conflict and eating disorder but even the strongest findings of an association fall short of the requirement of an explanatory model of identifying necessary conditions for the development of a disorder. The main argument arising from this is that the existing theoretical models do not provide a good basis for identifying targets of treatment or a model of change.

A theory for clinical practice

Once we abandon the search for the 'anorexogenic' family and accept that eating disorders develop in a variety of family contexts, the question that has to be addressed is the apparent similarity of

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experiences that families describe of what it is like living with someone with anorexia nervosa and why at least at a clinical level (I am not aware of any attempts to research this so far) it seems almost universal for families to agree that the eating disorder takes over almost every aspect of their lives. As a clinician, what I am struck with time and time again is the similarity of the processes through which the family becomes organized around the problem. The fact that the families are not all the same and in many ways seem to represent the whole gamut of family structures and organizations one comes across in everyday life makes this similarity all the more remarkable.

The processes through which families accommodate to serious and enduring problems have been well described in relation to problem drinking (Steinglass *et al*., 1987) and chronic physical illness (Rolland, 1994, 1999; Steinglass, 1998) and are clearly also relevant to families living with anorexia nervosa. Whatever the family is like before the eating problem appears, the impact on the family once the problem is there is immense and has been well documented (see Nielsen and Bará-Carril (2003) for a review). Over time the problems around eating, the anxieties and the concerns about how to manage increasingly dominate every aspect of family life, every relationship in the family and every family routine. Steinglass (1998) has described in some detail the process of family reorganization around chronic illness in which there is an increasing disruption of family routines, of the customary family regulatory mechanisms, where day-to-day decision-making becomes more and more difficult to the point where the problem becomes *the central organizing principle* of the family's life.

Family members trying to cope with an eating disorder in their midst will often say that they feel as if time had come to a standstill and that all of their lives seem to revolve around the eating disorder. The way families respond to this invasion into their lives will vary depending on the nature of the family organization, the family style of each individual family and the particular life-cycle stage they are at when the illness occurs. However, as with other illnesses, what may be less variable is the way in which the centrality of the eating disorder magnifies certain aspects of the family's dynamics and narrows the range of their adaptive behaviours. Understanding how families reorganize themselves around a problem is far more important from a treatment point of view than knowing how the problem itself developed partly because the way the family is currently functioning may have become part of what maintains the problem and partly

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because it may be limiting the family's ability to use its adaptive mechanisms to help overcome the problem.

The following are put forward as aspects of family reorganization that we have observed in families with whom we have worked in treatment.

1 The central role of the symptom in family life

The high levels of preoccupation with thoughts of food and weight that someone with anorexia manifests is paralleled by the way that issues around food and eating take centre stage in the family. As time goes on all relationships in the family seem to become defined by it. It becomes the 'currency' of relationship exchanges, the way in which the qualities of relationships are gauged. Much of the interaction between family members focuses on food, eating or weight. Just as the young woman may judge her self-worth by whether she is able to resist eating, so interpersonal relationships revolve around food (*'if you understood me, you wouldn't make me eat', 'you are not eating to get at us', 'no one seems to care that I am not eating'*).

2 Narrowing of time focus on the here-and-now

The anxiety engendered by the life-threatening nature of the problem and the intensity of interactions around meals which often take up the major part of the day result in the family gradually being unable to focus on anything other then the present. What happens at the next meal, indeed the next mouthful, takes on immense importance. The intense preoccupation with the present makes every failure at a mealtime seem overwhelming. The way this is played out will vary from family to family depending on their usual style of interaction. Families that tend to avoid conflict will see any argument as potentially disastrous and to be avoided at all costs. In other families conflict may be more common but is likely to be accompanied by intense feelings of guilt and blame (there is some evidence that this pattern may be more common in families having to contend with bulimic behaviours (Szmukler *et al*., 1985) but it is certainly also found in some families that are dealing with anorexia).

3 Restriction of the available patterns of family interaction processes

Lack of flexibility in the way families function is highlighted in many theoretical accounts of family functioning. What is usually emphasized

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is the importance of flexibility in enabling the family to deal with family life-cycle changes. For the clinician (or indeed the observational researcher) flexibility or rigidity is manifested in the moment-to-moment interaction. While the two kinds of flexibility are connected they are not one and the same. One should not automatically assume that an observation of rigidity in interaction signifies a family that finds negotiating life-cycle changes difficult. Whether a lack of flexibility is a pre-existing factor which has a contributory role in the development of eating disorders or simply a response to the problem may be difficult to determine (and may be different for different families). Either way it is often one of the most noticeable things when one first meets a family in the consulting room. The family is often as if 'frozen', fearful of doing anything outside of the usual routine. Many families often comment on this themselves. They know that what they are doing is not working but are afraid that doing something different could make things worse.

4 The amplification of aspects of family function

Faced with the painful and frightening nature of anorexic behaviour certain aspects of the family organization (in particular those which the family itself may have perceived as being unsatisfactory) become more pronounced. It is easy to assume that what we are observing is a manifestation of family dysfunction rather than the family's adjustment to the problem. For instance, there are many families where one parent has a much closer relationship with the children than the other parent, who may have a more peripheral role in the family (indeed there are many cultures where such a pattern is the norm).

When facing a life-threatening illness these positions may become more extreme and may in time be experienced in themselves as part of the problem (*'if only my husband was around more I would not have to be so involved with my daughter but the trouble is he doesn't really understand and when he does try to do something he just makes things worse'*). In some cases this may indeed become a problem in its own right (e.g. when anger turns to violence), and equally there will of course be families where the family problems pre-date the development of the eating disorder. While it may be important to understand how the two become intertwined it is equally important to emphasize their separateness (i.e. that one is not the cause of the other, and by implication that dealing with one is the solution to the other).

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A good example of this is the fairly common observation that clinicians make of problems in the marital relationship which can be anything from distance or tension in the couple to open discord or hostility. It can be tempting for the clinician to assume that it is the marriage where the 'real' problem lies (particularly if the child is caught up in the dispute) with the eating problem having the function of keeping the family together. In many cases what we observe is no more than the normal family life-cycle adjustment process made more visible (to us as well as to the family) by the presence of a life-threatening problem. Parents whose children are at the point of growing up and leaving home will become more focused on their own relationship and will frequently become aware that the close relationship that they had as a couple in the pre-parenting stage is no longer there and they have to find a different way of being a twosome rather than a threesome or moresome (and indeed some couples break up at this stage). If this is happening in the context of worries about their daughter's illness they may start blaming their 'not good-enough relationship' which may increase the distance between the couple. In some cases the child may be drawn into the marital dispute and the eating problem may take on a mediating role or sometimes keep the parents from breaking up completely. If the marital dispute clearly pre-dates the onset of the eating disorder the temptation to blame this for the eating disorder is even greater but equally mistaken, as would be the conclusion that marital therapy might be the answer to the eating problem.

5 Diminishing ability to meet family life-cycle needs

The processes described above all make it increasingly difficult to attend to the varying needs of the different family members and prevent the family from making the necessary adaptations needed to allow them to progress through the family life-cycle transitions. These disruptions have been described well elsewhere (Carter and McGoldrick, 1989) and need not be elaborated here.

6 The loss of a sense of agency (helplessness)

At the point when families seek treatment for their daughter they invariably feel helpless and despairing. Anorexia nervosa has sometimes been described as a 'disorder of control' (Fairburn *et al*., 1999), and many others have highlighted issues around the struggle for

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control and that anorexia may give the sufferer the sense that only through not eating can she be in control. What is most striking however when talking to families is that everyone in the family feels that they have lost control over their lives. Winning the battle with hunger may give the young person a brief sense of mastery and control but the battles around food that happen at mealtimes have the opposite effect, regardless of how successful she may be in resisting her parents' exhortations to eat. Parents will similarly recount that they feel helpless and have no control over what their daughter does and, like her, the struggle over control around food leaves them feeling that they have lost control over everything.

A model of treatment

In previous papers we have described the development of our treatment approach in the context of a series of randomized control trials (Dare *et al*., 1995; Eisler *et al*., 2003), the theoretical and conceptual influences (Dare and Eisler, 1995a) and the structure and stages of the treatment (Dare and Eisler, 1995b). We have also described the way the treatment approach has been adapted to use as part of a multiple family day treatment programme (Dare and Eisler, 2000; Eisler *et al*., 2003; see also Scholz *et al*. (2005 this issue)). The remainder of this paper will be used to describe the treatment approach linking it to the preceding analysis of the family reorganization around the developing eating problem. The starting assumption is that the family, like all social systems, has adaptive mechanisms that in a well-functioning family enable it to find a balance between maintaining stability and accommodating the changing needs of individual family members. The aim of the preceding analysis was to show how in the presence of serious and persistent problems such as anorexia nervosa these mechanisms may become increasingly unavailable (and of course in some families may have been relatively weak in the first place). The central aim of the treatment approach is to make use of the adaptive mechanisms that are available in the family both individually and in the family as a whole.

Phase 1 Engagement and development of the therapeutic contract

The first phase of treatment is similar in some ways to any other engagement of a family in therapy. The therapist engages the family in the usual way, making contact with each family member and

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identifying the focus for the work ahead. This is usually followed by an exploration of family perceptions of the problem and its development, and a discussion of the effects of the eating problem on the family as a whole. The therapist also tries to make connections with all family members through hearing the various narratives that different family members have about their experience of the problem, particularly those that are not at the forefront of the family's presentation, and asks questions that may enable or highlight alternative narratives or meanings to the ones that the family automatically presents ('*You told me that your father couldn't come today because he was too busy and that in any case he doesn't understand your problems. If he believed that he could help, do you think he would want to come? If it was possible for him to understand you better would you want that?*'). From the earliest part of the treatment the therapist focuses on exploring the strengths and resources in the family and what gets in the way of these being used to the maximum. Asking about beliefs as to the nature of the problem and its causes can be useful at this stage since they will frequently reveal feelings of guilt and blame which it is important to address early on.

The engagement phase has several features which are distinct and characteristic of our approach. From the very first contact with the family the therapist displays a lack of interest in the causes of the problem, emphasizing that the primary task is to overcome their daughter's anorexia. The reason for meeting family members is not because they are seen as the source of the problem but because they are needed to help their daughter to recover.

The main focus for engaging the family is very firmly problem-oriented. Assessment of the severity of the problem, its history and what the family has attempted to do to tackle it is combined with giving information about the effects of starvation, including the physical risks such as osteoporosis (cf. Zipfel *et al.*, 2003), effects on mood and cognitive processes (Channon and De Silva, 1985) and physiological effects such as delayed gastric emptying (Connan and Stanley, 2003). A detailed medical and risk assessment of the young person is an important part of the engagement and, like the process of giving information, plays an important role in shaping the therapeutic relationship with the therapist as well as the rest of the multidisciplinary team. It contributes to the creation of an environment where the family feels supported and has a sufficient sense of safety to be able to accept responsibility to look for alternative ways of managing the problem within the family.

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Descriptions of the eating disorder behaviours, weight loss and other symptoms are responded to with concern and a distinct lack of neutrality. If, as is often the case, the young person with anorexia denies that there is a problem, the therapist acknowledges the difficulty of her predicament but makes it clear that ensuring that her health and safety have to come first and that anorexia nervosa is too serious a problem to give her the benefit of the doubt.

Owning the expertise that the therapist together with the rest of the team have in eating disorders is contrasted from the start with the fact that they do not have the answer as to what any individual family will need to do to overcome the problem. The giving of information is also part of the process of labelling the eating problem as a quasi external force taking over their daughter's life which she is unable to resist on her own. This gives new meaning to some of the behaviours and experiences accompanying the eating problems. For instance, describing the effects on healthy volunteers of being starved (Keys *et al*., 1950; Allen, 1991), and the many parallels with someone suffering from anorexia nervosa (low mood, preoccupation with food, fear of losing control) can change the perception of the anorexic behaviours as being wilful and under the young person's control to something that has taken over and requires the combined efforts of the family to resist. This is reinforced by the use of 'externalizing conversations' (White, 1989) or in the context of multiple family therapy groups by role-playing of anorexia as an oppressive voice.

There are potential pitfalls in adopting an expert stance. Being in the position of expert may create problems of power and control in the therapeutic relationship, which can be undermining of the family and reinforce a sense of dependency on professionals. It can ally the therapist more obviously with the parents, making it more difficult to engage the young person. While it is important to be aware of these pitfalls one should not assume that they can be avoided by simply adopting a more neutral position, since they are as much a product of the nature of the problems as they are of the position adopted by the therapist. An awareness of these issues and a willingness to address them openly with the family is more effective than attempting to avoid them ever occurring.

The problem-focused orientation fits with the here-and-now focus of the family which is reinforced by the nature of the assessment, the emphasis on physical risk and the need to implement step-by-step changes to get the eating problem under control. Unlike the family, the therapist also holds a broader time frame (based on the experience

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of having been through the process of therapy with other people) which extends to the future and includes an expectation of change. The therapist conveys this by describing the nature of treatment being offered and the part families generally play in this, emphasizing that, like they themselves, most families at this stage of treatment do not believe that they can help, and that the therapist and the rest of the team are there to help them through this difficult time.

Phase 2 Helping the family to challenge the symptoms

The second phase of treatment is primarily concerned with dealing with symptoms. In some families this happens fairly rapidly and dramatically, but more commonly this is a gradual, step-by-step process. There is a great deal of variability in the way families respond to the idea that parents should have a key role in dealing with the eating problem. For some, particularly if the problem is of relatively short duration, it is reasonably easy to accept that the parents and the adolescent are jointly fighting something that has invaded their lives and, even though the daughter may at times feel cornered and frightened when facing food, she may herself (outside of mealtimes) encourage her parents not to back off.

In other families there may be initial protracted negotiations which, if they take place during therapy sessions, may require the therapist to repeatedly question whether the negotiations are with the 'anorexic voice' or a discussion with an adolescent about reasonable alternatives of food choices. In such situations parents often rely on the therapist to be the voice of authority of what their daughter needs. In accepting such a role it is often helpful to acknowledge openly the intentional aspect of the clinician's expert stance (*I'm sure you know what someone of your daughter's age needs to eat to gain weight but I am more than happy to give you a diet sheet if it is going to help you not to listen to the anorexic voice speaking for your daughter*'). If the problem has been going on for a long time and particularly if attempts at confronting the anorexia have led to overt criticism, hostility or even violence, the family may feel paralysed, frustrated and angry with the therapist for not helping them to avoid conflictual situations.

Detailed exploration of what happens at mealtimes and how this might need to change has to be accompanied by challenging beliefs about the impossibility of parental action, exploration of customary parental roles and how these have been undermined by the eating

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disorder. At this stage the parents often express their wish for detailed instruction of how they should manage mealtimes. Such requests are best met by describing a range of things which other families have tried, being clear that what works for one family does not necessarily work for everyone.

In the past we have advocated the use of family meals as part of the early stage of treatment in order to be able to observe at first hand the way the family manages mealtimes and to be able to intervene directly in supporting the parents in overcoming the anorexia. These sessions often ended up being highly confrontational and were experienced by many families as unhelpful (Squire-Dehouck, 1993). Moreover, we found that conjoint family therapy which included a family meal and separated family therapy (i.e. parents being seen by the same therapist but in separate sessions from their daughter, which by definition could not include a family meal) were equally effective (Le Grange *et al*., 1992) and we therefore stopped using them as a routine part of treatment. Others have continued to find these sessions useful (Lock *et al*., 2001) and acceptable to most families (Krautter and Lock, 2004). In our multiple family day programme, joint family meals are an important part of the programme and from time to time we will also suggest to family members being seen separately that such a session might help move things on.

In the context of multiple family day treatment this phase has an intensity that is unusual in work with individual families. The shared experience of what it is like for families to live with anorexia quickly helps to create a group cohesion and a supportive atmosphere in which difficulties can be tackled and new things tried without being paralysed by the usual fear that *'doing something different could make things worse'*. Although each family generally remains focused on their own here-and-now they soon realize that each of the other families is in a somewhat different phase (*'Until about six months ago, like you I used to think that asking my husband to help me would just upset our daughter and make things worse so I didn't ask. Then after we had a big row about it I realized that it wasn't fair for me to be angry with him if I wasn't willing to let him help me; tell John that you need him to come home from work earlier'*). Hearing how other families have overcome problems helps families to broaden their own time frame and consider trying out new things. The week-long programme also makes it possible to approach the problem of helping the adolescent eat in a number of different ways which include joint (multi) family meals supported by staff, role-plays of mealtimes with parents and young people swapping roles, parent

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group discussions of 'tricks that anorexia plays' and many others (Eisler *et al*., 2003; Scholz *et al*., 2005, this issue).

In our experience the four-day block which forms the early part of the intensive multi-family programme has a major impact on the families' sense of agency. Having mostly started the programme with a sense of helplessness and an expectation that it is up to the professionals to find solutions, they leave with a determination and a renewed belief in their ability to find their own solution. When working with families individually this shift is equally important but is usually less striking and is generally slower to achieve.

Phase 3 Exploring issues of individual and family development

Phase 3 is the least structured and least predictable part of the treatment. It starts at the time that the concerns around eating and weight recede. The focus of sessions becomes much broader, exploring consequences of being better on the activities and relationships of the whole family. Initially, parents continue to have anxieties about any changes in eating patterns and may be reluctant to reduce their vigilance at mealtimes. If they have disagreements or clash with their daughter they may find it difficult to differentiate between 'adolescent' and 'anorexic' behaviour, and the earlier externalization of problems may need to be replaced with 'de-externalization' (*'How do you tell if it is anorexia shouting at you or just your daughter being irritated with what you are doing?', 'Have you found ways of winding up your parents other than by not eating?'*).

Parental uncertainty and a reluctance to let go of the safety of control of eating and weight of their daughter is often matched by the daughter's own fears and uncertainties of what life without anorexia is going to be about. Exploring issues of independence, adolescent identity and self-esteem as well as addressing issues of how parents meet their own needs takes on a more central focus.

It is important, however, that we do not automatically assume that these issues are being addressed as somehow representing the dysfunction underlying the eating disorder. In many cases all one is doing is talking about normal developmental issues that have been put on hold by the anorexia. Families will often comment that during the time when anorexia dominated family life, everything was put on hold and time came to a standstill. As anorexia loses its grip they may initially tend to look to the past to a time before anorexia. Looking ahead to the future may feel less certain and requires a degree of

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self-reflection by the family which in normal circumstances they may not have had to undergo. Families sometimes comment that having had to struggle with anorexia has already forced them to look at themselves and decide what aspects of their relationships they like and what they want to change. Such changes may have taken place anyway under normal circumstances due to the usual demands of the family life-cycle transition, but they may have happened more gradually and in a less overt way.

Explorations of family background, family values and the cultural context of the family can be very useful at this stage, particularly if the focus is clearly on strengths and resilience. In this phase it is particularly useful to use interventions that span different time frames. In individual family sessions this may include the use of future questioning, getting the adolescent to observe her parents discussing their own experience of growing up or other aspects of their genograms, and so on. These techniques are particularly useful in families where issues emerge that seem too difficult to talk about. Shifting to a different time frame changes the intensity and immediacy of the feelings aroused by the topic and may make it possible to open up areas that may otherwise be too threatening or guilt-provoking (*in one family, for instance, a father was only able to acknowledge his harshness to his children when asked to think what kinds of stories he thought his daughter might tell her own children about him; he was then able to talk about the fact that he had never been able to forgive his own father for beating him as a child and his hope that this would not happen between him and his daughter)*.

Similar work can be done in the multi-family context using a variety of multi-family group techniques. For instance, the adolescents may be asked to imagine that they are in a time twenty years hence and are writing an article (or making a video film) about how they recovered from anorexia and how their lives and their relationships changed. Useful discussions can be generated in the group, doing family sculpts of the family with and without anorexia present, doing a time line showing how different family members will be affected by the gradual disappearance of anorexia and how their needs will be met and so on. Another technique is to interview the adolescents as a group in role as one of their parents while the parents observe from behind a one-way screen and then asking the parents to reflect on what they heard.

At this stage of the treatment families vary considerably in terms of what they need or want to get out of continuing treatment. For some there is a relatively brief process of adjusting to life with a well daughter. For others, issues that have been obscured and/or inter-

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twined with the eating problem come to the fore and become a focus of the therapeutic work. Sometimes these are addressed most usefully in the family context but, for others, doing some work on specific issues in individual therapy is more relevant.

Phase 4 Ending and discussion of future plans

Ending treatment is again quite variable. For some families little more is required than a reflection on how far they have come and what they have learned about themselves. For other families the process of ending therapy highlights the parallels between the difficulty parents may have in handing back control of eating to their adolescent and the process of growing up and becoming independent. Ending may become protracted when these processes bring forward the therapist's own wishes to see things through until 'all problems have been resolved'. Discussions of whose responsibility it would be to do something if eating problems re-emerged and returning to themes of safety and uncertainty may be important at this stage.

For those involved in a multi-family group programme there are separate issues concerning the ending of the group and ending therapy. For the group context it is useful to reinforce the central idea of the programme that it is the families rather than the professionals who hold the responsibility for what happens in their lives. The family group may devise a ritual to mark the ending of the group, or the parents and adolescent may each do this separately.

Ending the group is not coterminous with ending treatment. For some families treatment may come to an end with just a final goodbye session following the ending of the group, whereas other families may need to continue for some further time on an individual basis.

Conclusion

The argument put forward in this paper is that while there is strong evidence showing the effectiveness of family therapy for anorexia nervosa (at least in adolescence) the theoretical base from which such treatment is derived is flawed. I have tried to show that this is due in part to the lack of empirical substantiation of the theoretical models that have been put forward to date, but perhaps more importantly that models which aim to explain the disorder are almost inevitably destined to fail. I have suggested that rather than searching for aetiological models of disorders we should direct our attention to

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possible processes which lead to families reorganizing around a developing problem in a way that may either contribute to the maintenance of the problem and/or prevent the family from being able to use their normal adaptive mechanisms to deal with change.

The treatment model outlined in this paper is offered as a description of the treatment that we have evolved in the context of conducting a series of treatment studies. The conceptual framework is one that informs our approach to both individual family therapy and multiple family day group therapy. Implicit in the model are a number of mechanisms of change which we believe are addressed by the treatment, although these have not been elaborated here. The model has not as yet been subject to any empirical evaluation, although clearly this would be desirable.

In evaluating the proposed model it is important to keep in mind that it is unlikely that the mechanisms proposed will be uniform in all families with someone who develops anorexia nervosa. While there may be some commonalities, the more interesting question from a treatment point of view is the variability in this group of families and what impact this has upon treatment. For instance, studies of expressed emotion in eating disorders have shown that while most families are low in criticism or hostility (Le Grange *et al*., 1992; Hodes *et al*., 1999), the small number who are critical are precisely those who either do not engage well in family therapy (Szmukler *et al*., 1985) or, if they do, tend to have a poorer outcome (van Furth *et al*., 1996; Eisler *et al*., 2000). We have described elsewhere the way our attempt to gain an understanding of these findings led to new research exploring the links between criticism and self-blame (Besharat *et al*., 2001) and contributed to the changes in our clinical practice (Dare *et al*., 1995).

When we move the focus of family research away from questions of aetiology to questions of interaction between family function and treatment (or change in general) the gaps in our knowledge become all too visible. We may have begun to acquire reasonable knowledge of which treatments work but we still know very little about how treatment works, what facilitates it and what prevents it from working.

References

Allen, J. (1991) *Biosphere 2: The Human Experiment*. New York: Viking.

Ball, J. and Mitchell, P. (2004) A randomized controlled study of cognitive behavior therapy and behavioral family therapy for anorexia nervosa patients. *Eating Disorders: The Journal of Treatment & Prevention*, **12**: 303–314.

© *2005 The Association for Family Therapy and Systemic Practice*

Beavers, R. W. (1982) Healthy, midrange, and severely dysfunctional families. In F. Walsh (ed.) *Normal Family Processes*. New York: Guilford Press.

Besharat, M. A., Eisler, I. and Dare, C. (2001) The self- and other-blame scale (SOBS): the development and reliability of an observational measure of guilt and blame in families. *Journal of Family Therapy*, **23**: 208–223.

Blouin, A. G., Zuro, C. and Blouin, J. H. (1990) Family environment in bulimia nervosa: the role of depression. *International Journal of Eating Disorders*, **9**: 649–658.

Bowers, W. A., Evans, K. and Van Cleeve, L. (1996) Treatment of adolescent eating disorders. In M. A. Reinecke and F. M. Dattilio (eds) *Cognitive Therapy with Children and Adolescents: A Casebook for Clinical Practice*. New York: Guilford Press.

Bruch, H. (1974) *Eating Disorders: Obesity, Anorexia Nervosa and the Person Within*. London: Routledge & Kegan Paul.

Carr, A. (2000) Evidence-based practice in family therapy and systemic consultation. I: Child-focused problems. *Journal of Family Therapy*, **22**: 29–60.

Carter, B. and McGoldrick, M. (eds) (1989) *The Changing Family Life Cycle: A Framework for Family Therapy* (2nd edn). London: Allyn & Bacon.

Channon, S. and De Silva, W. P. (1985) Psychological correlates of weight gain inpatients with anorexia nervosa. *Journal of Psychiatric Research*, **19**: 267–271.

Connan, F. and Stanley, S. (2003) Biology of appetite and weight regulation. In J. Treasure, U. Schmidt and E. van Furth (eds) *Handbook of Eating Disorders: Theory, Treatment and Research* (2nd edn). London: Wiley.

Dallos, R. (2004) Attachment narrative therapy: integrating ideas from narrative and attachment theory in systemic family therapy with eating disorders. *Journal of Family Therapy*, **26**: 40–65.

Dare, C. (1983) Family therapy for families containing an anorectic youngster. In *Understanding Anorexia Nervosa and Bulimia*. Report of the IVth Ross Conference on Medical Research. Ohio, Columbus: Ross Laboratories.

Dare, C. and Eisler, I. (1995a) Family therapy. In G. I. Szmukler, C. Dare and J. Treasure (eds) *Handbook of Eating Disorders: Theory, Treatment and Research*. London: Wiley.

Dare, C. and Eisler, I. (1995b) Family therapy. In G. I. Szmukler, C. Dare and J. Treasure (eds) *Handbook of Eating Disorders: Theory, Treatment and Research*. London: Wiley.

Dare, C. and Eisler, I. (2000) A multi-family group day treatment programme for adolescent eating disorder. *European Eating Disorders Review*, **8**: 4–18.

Dare, C., Eisler, I., Russell, G. F. M., Treasure, J. and Dodge, E. (2001) Psychological therapies for adult patients with anorexia nervosa. A randomised controlled trial of out-patient treatments. *British Journal of Psychiatry*, **178**: 216–221.

Dare, C., Eisler, I., Colahan, M., Crowther, C., Senior, R. and Asen, E. (1995) The listening heart and the chi-square: clinical and empirical perceptions in the family therapy of anorexia nervosa. *Journal of Family Therapy*, **17**: 19–45.

Eisler, I. (1995) Family models of eating disorders. In G. I. Szmukler, C. Dare and J. Treasure (eds) *Handbook of Eating Disorders: Theory, Treatment and Research*. London: John Wiley & Sons.

© *2005 The Association for Family Therapy and Systemic Practice*

Eisler, I., Le Grange, D. and Asen, K. (2003) Family interventions. In J. Treasure, U. Schmidt and E. van Furth (eds) *Handbook of Eating Disorders: Theory, Treatment and Research* (2nd edn). London: Wiley.

Eisler, I., Simac, M., Russell, G. F. M. and Dare, C. (submitted) A treatment trial of two forms of family therapy for adolescent anorexia nervosa: five-year follow-up.

Eisler, I., Dare, C., Hodes, M., Russell, G. F. M., Dodge, E. and Le Grange, D. (2000) Family therapy for adolescent anorexia nervosa: the results of a controlled comparison of two family interventions. *Journal of Child Psychology and Psychiatry*, **41**: 727–736.

Eisler, I., Dare, C., Russell, G. F. M., Szumukler, G. I., Le Grange, D. and Dodge, E. (1997) Family and individual therapy in anorexia nervosa. A 5-year follow-up. *Archives of General Psychiatry*, **54**: 1025–1030.

Epstein, N. B., Bishop, D. S. and Levin, S. (1978) The McMaster model of family functioning. *Journal of Marital and Family Counselling*, **40**: 19–31.

Fairburn, C. G., Shafnan, R. and Cooper, Z. (1999) A congnitive behavioural theory of anorexia nervosa. *Behaviour Research and Therapy*, **37**: 1–13.

Fonagy, P., Leigh, T., Steele, M., Kennedy, R., Matton, G., Target, M. and Gerber, A. (1996) The relationship of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology*, **64**: 22–31.

George, C., Kaplan, N. and Main, M. (1985) *The Adult Attachment Interview*. Unpublished manuscript, University of California at Berkeley, Department of Psychology, Berkeley, CA.

Herscovici, C. R. and Bay, L. (1996) Favourable outcome for anorexia nervosa patients treated in Argentina with a family approach. *Eating Disorders: The Journal of Treatment and Prevention*, **4**: 59–66.

Hodes, M., Dare, C., Dodge, E. and Eisler, I. (1999) The assessment of expressed emotion in a standardised family interview. *Journal of Child Psychology and Psychiatry*, **40**: 617–625.

Humphrey, L. L. (1989) Observed family interactions among subtypes of eating disorders using structural analysis of social behavior. *Journal of Consulting and Clinical Psychology*, **57**: 206–214.

Jacob, F. (2001) *Solution Focused Recovery from Eating Distress*. London: BT Press.

Jeammet, P. and Chabert, C. (1998) A psychoanalytic approach to eating disorders: the role of dependency. In A. H. Esman (ed.) *Adolescent Psychiatry: Developmental and Clinical Studies, Vol. 22. Annals of the American Society for Adolescent Psychiatry*. Hillsdale, NJ: The Analytic Press.

Keys, A., Brozek, J., Henschel, A., Mickelsen, O. and Taylor, H. L. (1950) *The Biology of Human Starvation* (2 vols). Minneapolis, MN: University of Minnesota Press.

Kog, E. and Vandereycken, W. (1989) Family interaction in eating disordered patients and normal controls. *International Journal of Eating Disorders*, **8**: 11–23.

Krautter, T. and Lock, J. (2004) Is manualized family-based treatment for adolescent anorexia nervosa acceptable to patients? Patient satisfaction at the end of treatment. *Journal of Family Therapy*, **26**: 66–82.

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Lay, B., Jennen-Steinmetz, C., Reinhard, I. and Schmidt, M. H. (2002) Characteristics of inpatient weight gain in adolescent anorexia nervosa: relation to speed of relapse and readmission. *European Eating Disorders Review*, **10**: 22–40.

Leff, J. and Vaughn, C. E. (1985) *Expressed Emotion in Families: Its Significance for Mental Illness*. New York: Guilford Press.

Le Grange, D., Eisler, I., Dare, C. and Russell, G. F. M. (1992) Evaluation of family therapy in anorexia nervosa: a pilot study. *International Journal of Eating Disorders*, **12**: 347–357.

Lock, J., Le Grange, D., Agras, W. S. and Dare, C. (2001) *Treatment Manual for Anorexia Nervosa*. New York: The Guilford Press.

Luepnitz, D. A. (1988) *The Family Interpreted: Psychoanalysis, Feminism and Family Therapy*. New York: Basic Books.

McNamara, K. and Loveman, C. (1990) Differences in family functioning among bulimics, repeat dieters, and non-dieters. *Journal of Clinical Psychology*, **46**: 518–523.

Madanes, C. (1981) *Strategic Family Therapy*. San Francisco, CA, and London: Jossey-Bass.

Madigan, S. P. and Goldner, E. M. (1998) A narrative approach to anorexia: discourse, reflexivity & questions. In M. F. Hoyt (ed.) *The Handbook of Constructive Therapies*. San Francisco, CA: Jossey-Bass.

Martin, F. E. (1985) The treatment and outcome of anorexia nervosa in adolescents: a prospective study and five year follow-up. *Journal of Psychiatric Research*, **19**: 509–514.

Mayer, R. D. (1994) *Family Therapy in the Treatment of Eating Disorders in General Practice*. M.Sc. dissertation, Birkbeck College, University of London.

Minuchin, S., Rosman, B. L. and Baker, L. (1978) *Psychosomatic Families: Anorexia Nervosa in Context*. Cambridge, MA: Harvard University Press.

Minuchin, S., Baker, L., Rosman, B. L., Liebman, R., Millman, L. and Todd, T. C. (1975) A conceptual model of psychosomatic illness in childhood. *Archives of General Psychiatry*, **32**: 1031–1038.

Moos, R. and Moos, B. (1981) *Manual for the Family Environment Scale*. Palo Alto, CA: Consulting Psychologists Press.

NICE (2004) *Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders*. London: National Institute of Clinical Excellence.

Nielsen, S. and Bará-Carril, N. (2003) Family, burden of care and social consequences. In J. Treasure, U. Schmidt and E. van Furth (eds) *Handbook of Eating Disorders*. London: John Wiley.

Olson, D. H., Sprenkle, D. H. and Russell, C. S. (1979) Circumplex model of marital and family systems. I: Cohesion and adaptability dimensions, family types, and clinical applications. *Family Process*, **18**: 3–28.

Råstam, M. and Gillberg, C. (1991) The family background in anorexia nervosa: a population-based study. *Journal of the American Acadademy of Child and Adolescent Psychiatry*, **30**: 283–289.

Robin, A. L., Siegel, P. T., Moye, A. W., Gilroy, M., Dennis, A. B. and Sikand, A. (1999) A controlled comparison of family versus individual therapy for adolescents with anorexia nervosa. *Journal of the American Academy of Child and Adolescent Psychiatry*, **38**: 1482–1489.

© *2005 The Association for Family Therapy and Systemic Practice*

Røijen, S. (1992) Anorexia nervosa families – a homogeneous group? A case record study. *Acta Psychiatrica Scandinavica*, **85**: 196–200.

Rolland, J. S. (1994) *Families, Illness, and Disability: An Integrative Treatment Model*. New York: Basic Books.

Rolland, J. S. (1999) Parental illness and disability: a family systems framework. *Journal of Family Therapy*, **21**: 242–266.

Russell, G. F. M., Szmukler, G. I., Dare, C. and Eisler, I. (1987) An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Archives of General Psychiatry*, **44**: 1047–1056.

Sargent, J., Liebman, R. and Silver, M. (1985) Family therapy for anorexia nervosa. In D. M. Garner and P. E. Garfinkel (eds) *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*. New York: Guilford Press.

Scholz, M., Rix, M., Scholz, K., Gantcher, K. and Thömke, V. (2005) Multiple family group therapy for anorexia nervosa: concepts, experiences and results. *Journal of Family Therapy*, **27**: 132–141.

Schwartz, R. C. and Barrett, M. J. (1988) Women and eating disorders. *Journal of Psychotherapy and the Family*, **3**: 131–144.

Selvini-Palazzoli, M. (1974) *Self-starvation: From the Intrapsychic to the Transpersonal Approach to Anorexia Nervosa*. London: Chaucer Publishing.

Squire-Dehouck, B. (1993) *Evaluation of Conjoint Family Therapy Versus Family Counselling in Adolescent Anorexia Nervosa Patients. A Two Year Follow-up Study.* Institute of Psychiatry. Unpublished M.Sc. dissertation. University of London.

Steiger, H., Liquornik, K., Chapman, J. and Hussain, N. (1991) Personality and family disturbances in eating-disorder patients: comparison of 'restricters' and 'bingers' to normal controls. *International Journal of Eating Disorders*, **10**: 501–512.

Steinglass, P. (1998) Multiple family discussion groups for patients with chronic medical illness. *Families, Systems and Health*, **16**: 55–70.

Steinglass, P., Bennett, L. A., Wolin, S. J. and Reiss, D. (1987) *The Alcoholic Family.* New York: Basic Books.

Steinhausen, H. C., Rauss-Mason, C. and Seidel, R. (1993) Short-term and intermediate term outcome in adolescent eating disorders. *Acta Psychiatrica Scandinavica*, **88**: 169–173.

Stierlin, H. and Weber, G. (1987) Anorexia nervosa: lessons from a follow-up study. *Family Systems Medicine.*, **7**: 120–157.

Stierlin, H. and Weber, G. (1989) *Unlocking the Family Door.* New York: Brunner/Mazel.

Strober, M., Freeman, R. and Morrel, W. (1997) The long-term course of severe anorexia nervosa in adolescents: survival analysis of recovery, relapse and outcome predictors over 10–15 years in a prospective study. *International Journal of Eating Disorders*, **22**: 339.

Szmukler, G. I., Eisler, I., Russell, G. F. M. and Dare, C. (1985) Anorexia nervosa, parental 'expressed emotion' and dropping out of treatment. *British Journal of Psychiatry*, **147**: 265–271.

Treasure, J. and Schmidt, V. (2002) Anorexia nervosa. *Clinical Evidence*, **7**: 705–714.

Treasure, J. and Schmidt, V. (Submitted) Anorexia nervosa: valued and visible. A congitive-interpersonal maintenance model and its implications for research and pratice.

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van Furth, E. F., van Strien, D. C., Martin, L. M., van Son, M. J., Headricks, J. J. and van Engeland, H. (1996) Expressed emotion and the prediction of outcome in adolescent eating disorders. *International Journal of Eating Disorders*, **20**: 19–31.

Vandereycken, W. (2002) Families of patients with eating disorders. In C. G. Fairburn and K. D. Brownell (eds) *Eating Disorders and Obesity. A Comprehensive Handbook* (2nd edn). New York and London: Guilford Press.

Vostanis, P., Burha, J. and Harris, Q. (1992) Changes of expressed emotion in systemic family therapy. *Journal of Family Therapy*, **14**: 15–27.

Waller, G., Calam, R. and Slade, P. (1989) Eating disorders and family interaction. *British Journal of Clinical Psychology*, **28**: 285–286.

White, M. (1989) The externalizing of the problem and the re-authoring of lives and relationships. *Dulwich Newsletter*, **Summary**: 5–28.

Wilson, G. T. and Fairburn, C. G. (1998) Treatments for eating disorders. In P. E. Nathan and J. M. Gorman (eds) *A Guide to Treatments that Work*. New York: Oxford University Press.

Zipfel, S., Löwe, B. and Herzog, W. (2003) Medical complications. In J. Treasure, U. Schmidt and E. van Furth (eds) *Handbook of Eating Disorders* (2nd edn). London: John Wiley.

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