Family Interventions in Adolescent Anorexia Nervosa

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KEYWORDS

• Children and adolescents • Anorexia nervosa
• Eating disorders • Family therapy

HISTORY OF THE FAMILY'S ROLE IN EATING DISORDERS

The view that the family has a central role in eating disorders can be traced at least as far back as the late 19th century. The views about the role of parents in anorexia nervosa (AN) varied from Lasegue's[1] neutral stance in taking into account the "preoccupations of relatives," to Gull,[2] considering parents as "generally the worst attendants," and Charcot[3] thinking that their influence is "particularly pernicious." These early descriptions did not see parents as playing a helpful role in their daughter's illness, and indeed one of the earliest debates in the literature on AN was about whether it was at all possible to treat the patient without isolating her from her family.[4,5]

During the first half of the 20th century the family continued to be seen primarily as a hindrance to treatment,[6,7] which together with a general notion that the family environment had at least a contributory role in the development of the illness[7,8] generally led to the exclusion of parents from treatment, sometimes referred to pejoratively as a "parentectomy."[9] It is not until the 1960s that the authors find a major shift in thinking about the role of the family in eating disorders in the work of Bruch,[10,11] Palazzoli,[12] and in particular Minuchin and colleagues[13,14] at the Child Guidance Center in Philadelphia. The theoretic models suggested by these investigators, posited specific family mechanisms underpinning the development of AN, which could be targeted by

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treatment. Thus the psychosomatic family model, developed by Minuchin and colleagues,[14] hypothesizes that the prerequisite for the development of AN was a family process characterized by rigidity, enmeshment, overinvolvement, and conflict avoidance, which occur alongside a physiologic vulnerability in the child, and the child's role as a go-between in cross-generational alliances.[13,14] Minuchin did not place blame on the parents, highlighting the evolving, interactive nature of this process and emphasizing that the psychosomatic model was more than an account of a familial origin for AN. Nonetheless, Minuchin and colleagues still maintained that the psychosomatic family process is a necessary *context* for the development of AN and that the aim of treatment is to *change* the way the family functions.

This conceptual shift of explaining AN as being part of an evolving interactional family context had a profound impact on the development of treatments even though, as described later, the empiric foundation of the ''psychosomatic family'' model has been shown to be weak. The principal change arose from seeing the family as needing to take an active part in treatment to facilitate the change of some of the patterns of family interaction that had evolved around and had become intertwined with the eating problems. An important aim of the treatment model was to strengthen the parental subsystem to challenge what were seen as problematic cross-generational alliances and over-close, enmeshed relationships that were making it difficult for the parents to respond to their concerns for their daughter's health in an active and united way.[15]

Since the early work of Minuchin and colleagues and some of the other pioneer figures of the family therapy field, such as Palazzoli,[12] Stierlin and Weber,[16] and White,[17] family therapy has gradually established itself as an important treatment approach for adolescent AN supported by growing empiric evidence of its efficacy. This development has undoubtedly been one of the important factors in the major changes in the treatment of eating disorders that the field has witnessed in the past 10 to 15 years.[18]

Paradoxically, alongside the data for the efficacy of family therapy, there has also been growing evidence that the theoretic models, from which the family treatment of eating disorder was derived, are flawed.[19,20] There has been considerable research endeavoring to uncover characteristics that are specific to families in which an offspring has an eating disorder and to test the specific predictions of the psychosomatic family model with generally disappointing and inconsistent findings.[21,22] There is a growing indication that families in which someone has an eating disorder are a heterogeneous group not only with respect to sociodemographic characteristics but also in terms of the nature of the relationships within the family, the emotional climate, and the patterns of family interaction.[20] Although there is some evidence that family therapy is accompanied by changes in family functioning,[23,24] these changes are not necessarily in keeping with the psychosomatic family model and the changes may not apply consistently across all families. This fact inevitably brings to the fore the question of what the targets of effective family interventions should be and what processes underlie any resultant change. This has necessitated a second conceptual shift, away from an emphasis on family etiology of the eating disorder toward an understanding of the evolution of the family dynamics in the context of the development of an eating disorder, which may function as maintenance mechanisms.[19,25] This has gone hand-in-hand with the development of a much more explicitly nonblaming approach to family treatment of adolescent AN in which the family is seen not as the cause of the problem but as a resource to help the young person in the process of recovery.[19,26–28] Before describing the current approaches to family intervention in eating disorders the authors review the existing evidence for their efficacy.