CHAPTER 1

Introduction and Background Information on Bulimia Nervosa

The Purpose of This Manual

Family work with adolescents who have bulimia nervosa (BN), though commonly provided in clinical settings, has little systematic empirical support, and therapists have few guidelines about how best to proceed with these interventions. BN is a disorder that primarily begins in middle and late adolescence and seems to bear some relation to difficulties associated with adolescent development. Therefore, approaches that take into account developmental issues associated with adolescence are probably most likely to succeed. In contrast to treatment for BN, family therapy to assist with adolescent anorexia nervosa (AN) is comparatively advanced. This manual is designed to address this gap and to provide clinical guidance on how to provide family therapy for BN. The form of family therapy described is specific in its utilization of parents and the family as a resource to assist the adolescent family member with BN. It is derived from the family-based treatment (FBT) for adolescent AN originally developed at the Maudsley Hospital and subsequently manualized for dissemination. As such, the manual's general interventions are identical in many cases and similar to those outlined in treating adolescent AN using FBT. However, the differences in the symptoms of BN, the personalities of adolescents with BN, and the families of adolescents with BN make the process and particulars of FBT substantively distinct from that provided to AN patients. Hence, this manual is at once derived from the FBT manual used for adolescent AN

while still offering a new application of the approach for a different population. It presents a treatment program that includes the details of specific sessions and phases of therapy.

The manual is an adaptation of a recently published family-based treatment manual for adolescent AN (Lock, Le Grange, Agras, & Dare, 2001). That treatment approach is derived from several controlled trials of family treatment for AN (Dare, 1985; Eisler et al., 1997, 2000; Le Grange, Eisler, Dare, & Russell, 1992; Russell, Szmukler, Dare, & Eisler, 1987) and was subsequently studied at Stanford University (Lock, Agras, Bryson, & Kraemer, 2005) and at the University of Chicago (Le Grange, Binford, & Loeb, 2005).

The overall perspective of this therapeutic approach is to view the parents and other family members as resources to help adolescent patients with BN. Parents, in particular, play key roles throughout the three phases that comprise this treatment. It has long been advocated that the viewpoint of parents should be taken into account when it comes to the treatment of their child with an eating disorder (Lasègue, 1873). In fact, for most medical illnesses and many psychiatric ones, parents and families are usually viewed as an asset. For a variety of reasons, though, families of adolescents with eating disorders have been maligned, though with little evidence. (Chapter 2 covers the full rationale for FBT.)

During the first phase of this treatment, parents are asked to challenge and disrupt dysfunctional eating behaviors, including specifically binge eating, purging, and excessive dieting. To accomplish these parental interventions often requires reinvigorating parental roles related to controlling and managing these behaviors. Empowering parents to take up these roles is a main goal of this phase of family treatment. In addition, the therapy focuses on supporting the disruption of these behaviors rather than on other psychological or developmental issues. Often the therapist finds that parents have not agreed on how to address the problem of their child's bulimia, so considerable emphasis is placed on the need for parents (when there are two) to agree on how to proceed. Nevertheless, the therapist refrains from directing the family members toward specific solutions and instead encourages them to work out for themselves the best way to challenge bulimic behaviors.

The second phase focuses on returning control of eating and weight-related concerns back to the adolescent. This phase can begin only after parents are confident that dysfunctional behaviors have abated. Practically this means that eating behaviors have returned to normal, weight is steady, and binge eating and purging have ceased. It is possible at this point to turn

to other family problems, insofar as they affect the adolescent shape and weight concerns and behaviors. Only in the third phase, when the adolescent herself* has demonstrated mastery over bulimic symptoms, do larger and more general adolescent and family issues come to the fore in treatment. Usually, this phase involves supporting the adolescent and family as the adolescent moves productively forward in her development. Specifically, this phase entails working toward increased personal autonomy for the adolescent, more appropriate family boundaries, and the need for the parents to reorganize their life together as their adolescent children become more independent.

The manual consists of 14 chapters. The first provides an introduction and overview of BN in adolescents. Chapter 2 provides an introduction to FBT for adolescents with BN and outlines in detail the therapy that will be the subject of the remaining chapters. Chapters 3–13 provide detailed instructions for how to conduct FBT for BN. Particular emphasis is devoted to the initial three sessions because these sessions set the tone and therapeutic style that are employed throughout the treatment. In these chapters, we describe therapeutic maneuvers undertaken by the therapist, their rationale, as well as illustrations of each.

In this introductory chapter we provide general background material on BN; the pertinent research literature, a profile of illness's presentation in adolescents, how it differs from adolescent AN, as well as treatment options and prognosis.

Overview of BN in Adolescents

Eating disorders are highly prevalent conditions that have a profound impact on the lives of adolescents and their families. BN is a disabling eating disorder that affects as many as 2% of young women. BN usually arises in adolescence, starting as young as 12 years of age, with peak onset at 18 years (Mitchell et al., 1987). Key features are binge eating accompanied by feelings of loss of control, guilt, and remorse. As in AN, there is a fear of fatness and repeated attempts to lose weight through dieting and/or compensatory purging behaviors (e.g., self-induced vomiting, laxative or diuretic abuse) (American Psychiatric Association, 1994; Russell, 1979).

*The feminine pronoun is used throughout this manual because most—but not all—patients with BN are female. However, this treatment approach is equally appropriate for male adolescents with BN.

BN is a major source of psychiatric morbidity and impairs several areas of functioning. Common comorbid psychiatric conditions include high rates of depression and anxiety, personality disorders, disturbances in social functioning, alcohol and drug abuse, and suicide attempts. Adolescents with BN experience significantly lower self-esteem than adolescents without an eating disorder (Crowther et al., 1985, 1986); in addition, adolescent patients with bulimia report significantly more suicidal ideation and suicide attempts than other adolescents (Franko et al., 2004; Hoberman & Garfinkel, 1990). There might be an association between sexual and physical abuse and binge and purge behavior among adolescents (Ackard et al., 2001; Waller, 1991), however, this issue has not been explored sufficiently in young patients. Beyond psychiatric morbidity, preoccupation with food and body weight can impair social, school, and work functioning.

Although BN is a psychiatric condition, it is also associated with significant medical complications, morbidity and mortality (Palla & Litt, 1988). As many as one quarter of patients may require hospitalization for medical reasons (Palmer & Guay, 1985; Fisher et al., 1995). Moreover, BN can be life threatening at times due to the physiological effects of recurrent binge eating and vomiting. Hypokalemia is common, and hypocalcemia, hypomagnesemia, hypophosphatemia, esophageal irritation and bleeding, Mallory–Weiss tears, gastric rupture, and large bowel abnormalities have all been noted (Schebendach & Nussbaum, 1992). The use of ipecac to induce vomiting can cause emetine cardiomyopathy, hepatic toxicity, or peripheral myopathy (Society for Adolescent Medicine, 1995). Body weight is usually within normal range, but dental caries, periodontal disease, and menstrual irregularities are common (25% of patients present with secondary amenorrhea, and 33% present with irregular menses). Potential medical instability in these patients, exacerbated by the fact that most tend to deny the severity of their conditions, causes a mortality risk.

Growth is a dynamic process in early adolescence, and severe nutritional deficits can occur in the absence of healthy and expected weight gain (Schebendach & Nussbaum, 1992). Early studies of dieting and binge-eating behaviors in community samples showed that 10–50% of adolescent girls and boys frequently engage in binge-eating behavior (Johnson et al., 2002; Jones et al., 2001; Stice et al., 1998, 1999; Whitaker et al., 1990). There is also evidence to suggest that disordered eating in males may be similar to that observed in females (Walsh & Wilson, 1997). BN may be as prevalent among non-Western and ethnic-minority females as it is among Caucasian adolescents (French et al., 1997; Stevens et al., 2003; Story et al.,

1995). BN is occurring with increasing frequency among adolescents and preadolescents. Applying stringent diagnostic criteria, studies have found that 2–5% of adolescent girls surveyed qualify for a diagnosis of BN (Walsh & Wilson, 1997). Several reports have described alarmingly high numbers of adolescents presenting with BN (Mitchell & Hatsukami, 1987; Stein, Chalhoub, & Hodes, 1998; Kent, Lacey, & McClusky, 1992; Russell et al., 1987). The relative frequency of premenarchal BN in children is particularly disconcerting (Maddocks et al., 1992). In contrast to adolescent AN, for which there is clear evidence that cases with early onset of illness have a better prognosis than those with late-onset illness (Steiner & Lock, 1998), the same is not true for BN. In a series of 32 BN cases with an age at onset of 15 years or younger, deliberate self-harm was more prevalent compared to later-onset cases. Nearly twice as many early-onset cases were overweight prior to illness when compared to typical, later-onset cases. Additionally, parental neglect was nearly twice as common in early-onset cases compared to typical-onset patients (Mitchell et al., 1991).

Clearly, BN is a highly prevalent and serious health concern that affects adolescents of both genders and across diverse ethnic groups. Although pertaining specifically to the treatment of adolescents with BN is limited, we review the available treatment approaches for adults with BN here.

Clinical Differences between AN and BN

Although AN and BN in adolescents share many clinical similarities (Le Grange, Loeb, Van Orman, & Gellar, 2004), the sometimes considerable differences between these two disorders need to be taken into account when FBT for BN is considered. There are specific diagnostic issues for which the therapist should map out a distinctive strategy for BN as opposed to AN:

1. *Comorbidity.* Perhaps the most prominent potential difference in clinical presentation between AN and BN is the presence of psychiatric comorbidities. It would be accurate to say that BN in adolescents covers a broader symptomatic front when compared to AN. The management of BN in adolescents may therefore be considerably more challenging, in that comorbid illnesses could conceivably derail the therapist from the primary task at hand. In AN, no comorbid condition other than acute suicidality

can trump self-starvation, making it more straightforward for the therapist in his/her attempt at "staying with" the eating disorder.

2. *Symptomatic emphasis*. Whereas AN is about the reduction of weight ostensibly for "health" reasons, BN is more about the overvaluation of shape. Moreover, the DSM draws a clear distinction between AN and BN; whereas the emphasis in AN is clearly on significant weight loss, BN focuses on binge-eating episodes followed by inappropriate compensatory behaviors, such as self-induced vomiting and laxative abuse.

3. *Family style*. Families of patients with BN are also perceived as presenting different relational styles from those of families of patients with AN. Whereas families of patients with AN tend to be more conflict avoidant and eager to maintain an impression of politeness, families of patients with BN often tend to be somewhat more disorganized and conflictive, inviting the therapist to establish some order.

4. *Pride versus shame*. BN is associated with considerable shame, and patients are reluctant to disclose their symptoms. For AN, on the other hand, shame is associated with eating, whereas patients often derive considerable pride in their symptoms. This difference may make change easier for BN; despite hiding symptoms, the shame associated with these symptoms may serve as a motivator for change.

There are also specific psychological aspects or characteristics for which the therapist should map out a distinctive strategy for BN as opposed to AN:

1. *Motivation on the part of the parents*. Young patients with eating disorders are seldom motivated for treatment, but with obvious signs of starvation in AN, it is probably easier for the parents to separate the illness from the patient and to be motivated to take charge of weight restoration. In BN, motivation is more mixed, and the therapist may have to work much harder to inform the parents about the secretive nature of the BN so that they can find a way to help their adolescent offspring who may not appear unwell.

2. *Independence*. Compared to the average patient with AN, young patients with bulimia often create the impression of having established a much greater degree of independence, even if this independence is often quite ambivalent. Whereas in AN the independence is usually self-willed, in BN it is more in reaction to others. In the end, neither the patient with anorexia nor the patient with bulimia is truly independent. The appearance

of greater independence can have obvious consequences for treatment, in that the parents may have come to accept the level of independence their daughter has established to the degree that it may be difficult to regroup to a position where they exert more control over her eating, and other freedoms, than they themselves would want to exert. Likewise, the adolescent with BN may not as readily accept her parents' perceived interference with her freedoms as many young patients with AN would. The parents' job is to help make the adolescent less anxious and to get back "on track" with adolescence. In other words, the parents are "repairing" their child; the adolescent with bulimia might still be regressed, albeit not as severely as the adolescent with anorexia.

3. *Psychological insight*. Some patients have insight into their dilemma whereas others do not recognize that they have a problem. The therapist will have much more of a challenge convincing the patient that her parents need to help her in her struggle with bulimia if she adamantly rejects the notion that she has a serious illness. However, in our experience, most adolescents with BN understand that they are unwell and are at least somewhat motivated to overcome their difficulties with eating (BN is experienced as more ego dystonic; see Chapter 3). On the other hand, adolescents with AN are mostly unwilling to entertain the thought that they are seriously ill—poses a denial that a particular dilemma for clinicians in helping these patients change their behaviors.

4. *Adolescent experimentation*. Adolescents with BN are more likely than their counterparts with AN to have experimented on a wider range of adolescent issues (e.g., romantic relationships, drugs). Not only may this complicate the therapist's efforts to keep the family focused on reestablishing healthy eating habits in the adolescent, but the parents may find it harder to intervene to the degree that the therapist may find desirable if they feel they have a relatively independent adolescent with many different experiences on their hands; someone whom they regard to be beyond their efforts at instruction or guidance.

5. *Peer pressure*. In keeping with the previous two issues, adolescents with BN are more connected to their peer group and may therefore feel more pressure to conform with the expectations of this group. Again, this may complicate the task of the therapist as well as that of the parents in finding a way in which they (the parents) can have a significant impact on the eating disorder of their adolescent in light of the expectations (e.g., for "perfect" bodies) of the peer group. However, the fact that the adolescent with AN is generally less connected with her

peer group and socially more isolated, makes treatment no less challenging, albeit for different reasons.

Treatment Approaches for Adolescent BN

Despite the availability of a large number of treatment studies for adult BN, none has specifically included or investigated adolescents with BN, that is, those ages 18 years or younger. Although AN and BN are distinct syndromes, considerable overlap in symptomatology is common. Therefore, treatments that have proved to be effective for adolescent patients with AN might also be beneficial for adolescent patients with BN. On the other hand, as noted, families with an offspring with AN may be different from those with offspring with BN, and these differences may have implications for the involvement of family members in therapy. Women with BN report more troubled childhood experiences than women with AN (Webster & Palmer, 2000). Our own studies have shown that there may be a greater likelihood of conflict or criticism in families with adolescent with BN compared to their counterparts with AN (Dare, Le Grange, Eisler, & Rutherford, 1994), but it is premature to talk about a "typical anorexic family" versus a "typical bulimic family." Notwithstanding, the secrecy of the bulimic behaviors, as opposed to the more obvious fragility of a starving teenager, and the general difficulty in engaging adolescents in therapy suggest that family intervention has an important place in both these disorders. From a developmental perspective, it is possible to argue that adolescent patients with BN or AN share similar challenges—for example, the negotiation of individuation, separation, and sexuality. Therefore, it is clinically feasible that adolescent patients with BN still living with their families of origin may benefit from FBT, albeit a therapy that accommodates differences between AN and BN in adolescents.

A discussion of family therapy for BN is incomplete without a brief reference to the Maudsley approach to family therapy for AN.

The Maudsley Approach and the Evolution of This Manual

The treatment of AN has been in the domain of family therapists for many years now (Dare & Eisler, 1997; Minuchin, Baker, Rosman, Liebman, Milman, & Todd, 1975; Selvini Palazzoli, 1974; Wynne, 1980), and family

problems have long been identified as part of the presentation of eating disorders (Bliss & Branch, 1960; Bruch, 1973; Gull, 1874; Morgan & Russell, 1975). In fact, according to Dare and Eisler (1997), AN can been seen as paradigmatic for family therapy, much as hysteria was seen as such for psychoanalysis and phobias for behavior therapy. Minuchin and his colleagues at the Philadelphia Child Guidance Clinic (1975) as well as Selvini Palazzoli at the Milan Center (1974) observed specific characteristics in families with offspring with AN. They emphasized the overly close nature of family relationships, the blurring of intergenerational boundaries, and tendencies to avoid overt conflict. In the model of therapy advanced by Minuchin, the patient is seen as having developed a problem in response to various factors (e.g., familial, genetic, physiological, sociocultural). In this model, family intervention attempts to modify the problems within the family or, if necessary, remove the child from the family (Harper, 1983). In contrast, the Maudsley approach to family therapy does not apportion any blame; instead, every effort is made to resolve the eating disorder, in great part, by viewing the parents as a resource. The Maudsley approach for adolescents with AN uses many of the insights and techniques found in earlier family therapy schools (e.g., structural, Milan, strategic, narrative).

Although there are a variety of case series on many of these types of family interventions, only the Maudsley approach has been the subject of controlled trials. These trials demonstrate the relative benefit of family therapy for adolescent patients (i.e., 18 years and younger) with a duration of illness of less than 3 years (Eisler et al., 1997, 2000; Le Grange, Eisler, Dare, & Russell, 1992; Lock et al., 2005; Russell et al., 1987). The Maudsley group has been conducting controlled family therapy studies since the mid-1980s. The most prominent of these is that of Russell et al. (1987), which compares treatment outcomes in AN and BN. They demonstrated that, compared to older patients, younger patients with AN improved with family therapy more than with individual therapy. A 5-year follow-up of the original cohort confirmed the maintenance of the positive outcome for the young patients who received family therapy (Eisler et al., 1997). In a controlled pilot study, this group set out to explore the beneficial components of this family therapy, as well as demonstrating the viability of family treatment as an outpatient therapy (Le Grange, Eisler, Dare, & Russell, 1992). In a follow-up and larger study, they confirmed that family therapy for AN is a viable alternative to inpatient treatment, and that there is a relationship between family organization and treatment compliance and outcome (Eisler et al., 2000).

Family therapy has also been shown to be effective in controlled studies conducted by Robin and his group in Detroit. They compared a family therapy very similar to the Maudsley approach to individual therapy in 22 adolescents with AN and found that after 16 months, family therapy resulted in greater changes in body mass index, whereas both treatments demonstrated similar results in other measures (eating attitudes, body-shape concerns, and eating-related family conflicts) (Robin, Siegel, Koepke, Moye, & Tice, 1994). A 1-year follow-up of this cohort again demonstrated the superiority of family therapy in terms of greater weight gain and higher rates of resumption of menses when compared to individual therapy. Although individual therapy also proved effective, family therapy produced a faster return to health (Robin et al., 1999). It is clear from this handful of controlled studies that family therapy appears to be particularly helpful in the treatment of adolescents with AN.

Since these earlier studies, the Maudsley approach to the family treatment of adolescents with AN has been manualized (Lock et al., 2001) and applied with success in a recent large randomized trial (Lock et al., 2005). The present manual, although aligned closely with the AN manual, was carefully adapted to address the specific needs of adolescents with BN.

Family Therapy for BN

In contrast to adolescents with AN, there are few systematic accounts of family therapy for patients with BN. However, there are single-case descriptions of family therapy of adults with BN (Madanes, 1981; Roberto, 1986; Root, Fallon, & Friedrich, 1986; Wynne, 1980), and three studies of family therapy that give a clear account of this treatment (Russell et al., 1987; Schwartz, Barrett, & Saba, 1985). Findings from these studies were inconclusive. In the first randomized controlled trial of family therapy for adults with BN, Russell and his colleagues at the Maudsley Hospital found no benefit for either the family or the individual treatments. Swartz and his colleagues, on the other hand, found that 66% of 30 patients with BN improved after 33 sessions of structural family therapy over a period of 9 months. Neither of these studies specifically investigated at adolescent patients with BN. Early evidence that a psychological treatment may be effective with an adolescent population with BN comes from a preliminary report from the Maudsley group. This investigation of family therapy for adolescents with BN revealed encouraging results. The finding in a small

cohort of eight adolescent patients with BN suggested that family therapy was helpful for this group of patients and their families (Dodge, Hodes, Eisler, & Dare, 1995). Inclusion of educational principles of the disorder and involvement of the parents in helping to stop the binge/purge cycle seemed to be successful. Most patients responded positively and showed significant changes in bulimic symptoms from the start of treatment to 1-year follow-up. These results should still be viewed with caution, however; this study described a small group of patients, follow-up was brief, and no control group was included.

Most relevant for the development of this manual, our own case study (Le Grange, Lock, & Dymek, 2003) as well as two large controlled trials of FBT for adolescents with BN that have recently been completed (see Le Grange & Schmidt, 2005) all show support for family-based treatment in this clinical population (see Chapter 2). Moreover, Eisler et al. (2000) and our own work (Lock & Le Grange, 2001) have demonstrated that the families of adolescents with AN binge/purge subtype respond well to parental attempts at curtailing bulimic symptoms.

As with many adolescent treatment paradigms, there are strong theoretical and clinical arguments for involving the family in treatment of adolescents with BN. Apart from any relevant family issues, heightened feelings of shame, guilt, and blame in the parents can reinforce the symptomatic behavior in the adolescent. In family therapy, information about the condition can be shared with the parents and the adolescent, and issues around meals and the impact of the eating disorder on family relationships can be addressed. Although sometimes not as severe as with patients with AN, adolescent patients with BN often exhibit a significant denial and minimization of the alarming nature of their bulimic symptoms that renders them incapable of appreciating the seriousness of their illness. This denial and minimization necessitate that the parents make sure that the adolescent receives adequate treatment. If the bulimic adolescent with bulimia is defined in the same manner as Robin, Siegel, Moye, Gilroy, Dennis, and Sikand (1999) conceptualized the teenager with anorexia—that is, "out of control" and "unable to take care of herself"—then the burden of providing that control and care must fall to parents. Parents of the adolescent with BN should be coached to work as a team in developing ways to restore healthy eating in their offspring. Therefore, FBT for adolescents with BN has considerable potential and should be investigated more systematically. More traditional approaches view the involvement of parents in the treatment of an adolescent at the cusp of establishing her autonomy

as undesirable and inappropriate. Although individual treatment is preferable when parents present with significant psychopathology or hostility toward their adolescent, engaging them in the treatment of their offspring is almost always advantageous.

Outcomes for Patients with BN

A number of studies have followed patients with BN over the relative long term. Almost all of these studies followed patients who had received some treatment, and all of them focused on adults with BN. On the whole only about half the patients studied were considered recovered from BN (Fairburn, Cooper, Doll, Norman, & O'Connor, 2000; Fairburn & Cooper, 2003; Jager et al., 2004; Keel et al., 2000). There was evidence of increased comorbid psychiatric risk, particularly depression and substance abuse (Fichter & Quadflieg, 2004). Although overall mortality risk was not higher than expected in the general population, deaths have been known to occur (Fichter & Quadflieg, 2004; Herzog et al., 2000, Patton, 1988). Further, relapse was common in about one-third of the patients in several studies (Fairburn et al., 2000; Fairburn & Cooper, 2003; Herzog et al., 1999). Additionally, findings suggest that suicidal thoughts and behavior are common, with about a quarter of adults with BN reporting suicide attempts. One important predictor of increased suicide risk is younger age of onset of BN (Franko et al., 2004). The fate of adolescents with BN is largely unexamined in these studies, but it is reasonable assume that there may be an accumulated risk based on early onset and longer duration over time for adolescents with BN.

Introduction to This Treatment Approach

In this manual we present a specific treatment approach to BN in adolescents based on (1) our manual for adolescents with AN (Lock et al., 2001), (2) the recently completed trial for adolescents with BN at the University of Chicago (Le Grange et al., 2006), as well as (3) our clinical experience with this patient population over the past 5 years or so. By making this treatment available in a manual, we hope that practitioners who embrace this method will discover more about its appropriate clinical use. We recognize that no treatment works for every patient or family under all conditions.

Thus we believe that, other than in research studies where strict protocols are needed, the judgment of individual clinicians need apply. This need for clinical judgment is no less true for this treatment than any other approach. Therefore, although we have endeavored to be as precise and specific as possible in the forgoing discussion, we recognize and fully expect clinicians to modify certain aspects of treatment to fit the circumstances within which they find themselves practicing. At the same time, there are certain principles of treatment that would hold, we believe, in every instance. Among these principles are:

1. An agnostic view of the cause of the illness, which holds the family innocent from the perspective of treatment;
2. A commitment to the parents as competent agents for reestablishing healthy eating in their adolescent;
3. A view of the entire family as an important resource in recovery; and
4. A need to respect adolescent needs for control and autonomy in areas other than weight and food.

We also believe that the pacing of the therapy should follow the overall guideline of the phases of treatment. That is to say, the focus of the initial period of treatment must be on reestablishing healthy eating behaviors and weight control strategies under the direction of the parents; not until these issues have been resolved is it advisable to proceed to discuss more general family dynamics or adolescent issues. We have included an outline of therapeutic interventions for each phase of treatment (Table 2.1, Chapter 2, this volume). We hope that this outline will help therapists who are using the manual to keep track of where they are in the treatment process and to follow the steps as outlined.

The theoretical understanding or overall philosophy of the Maudsley approach is that the adolescent is embedded in the family, and that the parents' involvement in therapy is vitally important for ultimate success in treatment. For AN, and to a lesser degree for BN, the adolescent is seen as regressed. Therefore, parents should be involved in their offspring's treatment, while showing respect and regard for her point of view and experience. This treatment pays close attention to adolescent development and aims to guide parents toward assisting their adolescent with developmental tasks. To do so, fundamental work on other family conflicts or disagreements has to be deferred until the eating disorder behaviors have been

eliminated. Normal adolescent development is seen as having been diverted by the presence of BN, varying, of course, in degree from patient to patient. The parents temporarily take the lead in helping their adolescent find ways to reduce the hold this disorder has over her life. Once successful in this task, the parents will return control over eating to their daughter and assist her in negotiating predictable adolescent developmental tasks.

The Maudsley approach differs from other treatments of adolescents in several key ways. First, as pointed out above, the adolescent is not viewed as being in control of her behavior; instead, the eating disorder is seen as controlling the adolescent. Provided there is no comorbid psychiatric condition, the adolescent is seen as not functioning in an optimal way and as possibly benefiting considerably from parental help. Second, the treatment aims to correct this position by giving the parents permission to involve themselves more actively in their adolescent's eating. Typically, parents feel that it is inappropriate to control their adolescent's life in this way and that they are to blame for the eating disorder, or the symptoms have frightened them to the extent that they are too afraid to act decisively. Third, the Maudsley approach strongly advocates that the therapist should primarily focus her/his attention on the task of addressing the eating disorder symptoms, especially in the early part of treatment. As opposed to Minuchin's approach, the Maudsley approach, tends to stay focused on the eating disorder for longer; that is, the therapist remains alert to the central therapeutic task, which is to keep the parents focused on reestablishing healthy eating in their adolescent so as to free her from the control of the eating disorder. The presence of comorbid psychiatric issues can, of course, derail the therapist as well as the family, because prioritizing the eating disorder in the presence of a severe mood disorder could be problematic. (See Chapter 2 for a more detailed discussion regarding comorbidity.)

Why Use a Manual?

Tension is sometimes experienced between the intuitive therapeutic relationship with a patient or family and the structure of a specific therapy described in a manual. This tension is, for the most part, a productive one. On the one hand, the particulars of each patient and family provide important information about the specific clinical situation at hand; on the other hand, the structured manual provides a general map with predictable guideposts that are relevant for many, if not all, patients and their families.

Some have argued that manuals are a "cookbook" for unimaginative therapists. These critics contend that patients are always, and in all ways, unique, and therefore their clinical needs cannot be anticipated by manuals. Further, they suggest that structured treatments rob the therapeutic situation of its soul by forcing both the therapist and patient into prefabricated theoretical structures and modes of interaction.

In contrast, defenders of manualized treatments argue that illnesses share common characteristics, modes of distorting thoughts, and reinforcing destructive behaviors. In this sense, a person with an illness is similar to any other with that illness. When an illness is diagnosed, the person with the illness joins the ranks of those similarly affected. For these practitioners, there is more appeal for an approach that anticipates the recovery process from an illness by providing both a general path as well as specific markers of progress. Following this line of debate, it is fair to say that there are benefits to both the therapist and the client when using a manual-based therapy. First, the structure, although flexible, ensures that the treatment procedures are sequenced in an optimal fashion and that all the components of therapy are adequately covered. Second, a manual keeps both the therapist and the client on track; without the structure of a manual it is easy to deviate from the central issue to issues that are not central to the treatment of BN in adolescents.

By writing this manual, our view of the usefulness of manuals is clear. However, few would argue that the best way to use a manual is to follow it to the letter in a lockstep fashion. Still, manuals are the only way, other than direct supervision, to provide therapists with information about treatments in a meaningful way. Effective treatments that remain available only in those few sites that develop them or become expert in their application are of limited value, because access is severely constrained by these limitations. Although a manual cannot anticipate every treatment problem or substitute for the unique relationships formed between therapist and patients and families, it can help to make use of the relationship in a focused way that is specifically designed to address the problem at hand.

Nowhere perhaps is the tension between individual needs and the benefits of a structured and specific intervention greater than in treating adolescents with eating disorders. In the case of BN, the developmental needs of a particular adolescent, in the context of the unique family context in which her illness arises, are set against the clear and compelling nature of the symptoms that link her to all other suffers of BN. In this manual we try

not to disregard this tension, but rather to respect it. Therapists, in putting the manual to use, will find that it generally applies to the clinical situations they face with adolescents who have BN, but they will also find a need to use themselves as the means through which the treatment evolves. No manual can or should substitute for the basic respect, interest, and commitment implied in the therapeutic relationship. At the same time, few patients with the severe distortions in thoughts and behaviors that accompany BN would expect to recover on the basis of a therapeutic relationship alone. Finally, then, this manual is a tool for therapists, not the therapy itself.

Conclusions

In this chapter we have reviewed the etiology, clinical presentation, treatment, and prognosis of BN. We have reviewed these issues in part to provide general background information for the reader. However, we also wished to stress several important aspects of BN and its treatment that bear specifically on the approach used in this manual. The first is that BN is a disorder that primarily begins in middle and late adolescence and seems to bear some relation to difficulties associated with adolescent development. As such, approaches that take into account the developmental issues associated with adolescence are most likely to succeed. In addition, although treatment approaches for adolescent BN have not been studied, we have noted that adolescent AN family-based approaches may be superior to individual approaches. In addition, limited data show that this same approach may be helpful for adolescents with BN.

Emphasizing a family-based approach may seem counterintuitive to some clinicians who prioritize the adolescent's need for autonomy and self-control that is indeed an expected part of adolescent development. Instead, our approach emphasizes that adolescents with BN, because of the compelling nature of the thoughts and behaviors associated with the disorder, are out of control and need the help of their parents to "get back on track" so that the usual work of adolescent individuation can be resumed without the symptoms of the eating disorder. Thus, families are seen as an important resource for adolescents in their struggle to combat the illness and ultimately recover from BN. For most medical illnesses and many psychiatric ones, this view of the parents and families as an asset is the usual one, though for a variety of reasons, families of adolescents with eating disorders have been maligned, with little evidence.

The manualized therapy described in the following chapters takes these observations into account. That is, it is designed to specifically address the need for parents to assist the adolescent in reestablishing healthy eating behavior, and it also aims to support the developing adolescent in the context of her family.

In summary, although systematic evidence of any specific treatment approach for adolescent BN is lacking, the manualized treatment described in the following pages represents a reasonable approach. It is also an approach that is successful with adolescents with AN who binge eat and purge, yet is modified to address the differences between the two disorders. The treatment for adolescents with BN, as outlined in this manual, can be characterized by the following key components: (1) the use of the parents to help the adolescent reestablish healthy eating habits, and (2) a sustained focus on eating disorder symptoms until normalized; that is, while general adolescent and family issues are deferred until the eating disorder behavior is well under control. The advantages of this approach and a more thorough discussion of its merits are the subject of Chapter 2.

Guilford Publications
72 Spring Street
New York, NY 10012
212-431-9800
800-365-7006
www.guilford.com