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Authors(s)	Carr, Alan, McDonnell, Dermot, Afnan, Shahin
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ANOREXIA NERVOSA: THE TREATMENT OF A MALE CASE WITH COMBINED BEHAVIOURAL AND FAMILY THERAPY

ABSTRACT

The successful treatment of a case of anorexia nervosa in a 14-year-old boy is described in this paper. The treatment comprised an initial month long hospital-based behavioural weight gain programme. Concurrently a family evaluation was conducted. Family therapy, involving the parents only, was conducted over a subsequent four month period. The management of a relapse four months after the termination of treatment is described and information obtained at 9 and 16 month follow up is presented.

INTRODUCTION

Anorexia nervosa occurs most commonly in young adult females and this population has been well-described (Garfinkel & Garner, 1982). Only recently have studies of younger anorexics (Jacobs & Isaacs, 1986; Fosson et al., 1987; Bryant-Waugh et al., 1988) and males (Beaumont et al., 1972) with this eating disorder been reported. The proportion of boys with anorexia is higher in the early teens than among young adults. (Fosson et al., 1987). Younger anorexics show more pre-morbid feeding difficulties and behavioural problems than their older counterparts and there is also a higher incidence of feeding difficulties among their relatives (Jacobs & Isaacs, 1986).

Major clinical features and associated family difficulties vary little with the age and sex of the anorexic family member. Most anorexics have a fear of obesity, refuse to maintain a normal body weight, and have a disturbed body image. Often secondary hormonal and psychological characteristics resulting from starvation may develop. Difficulty in the establishment of personal autonomy is a central concern for many anorexics (Bruch, 1973; Garner & Bemis, 1982). A high degree of interdependence among family members, mutual overprotectiveness, poor conflict resolution and rigid patterns of interaction and communication difficulties are among the main features commonly noted in families with an anorexic member (Minuchin et al., 1978; Selvini-Palazzoli, 1974; Fosson et al., 1987).

The treatment of families with anorexic members using both structural (Minuchin et al., 1978) and systemic (Selvini-Palazzoli, 1974) family therapy has been well-described. The therapy outcome literature suggests that family therapy may be the treatment of choice for this disorder, particularly in younger cases (Russell et al., 1987). Despite this, a literature review revealed no full length case study describing a complete course of family therapy with a young male anorexic. The present paper aims to fill this gap in the literature.

CASE STUDY

Circumstances of referral

In May 1986, Phil, aged 14, was assessed by his Family Doctor. His height and weight were at the third centile. Since Christmas 1985 he had lost 19 kg. The weight loss began when Phil was mocked at school for being overweight (54 kgs).

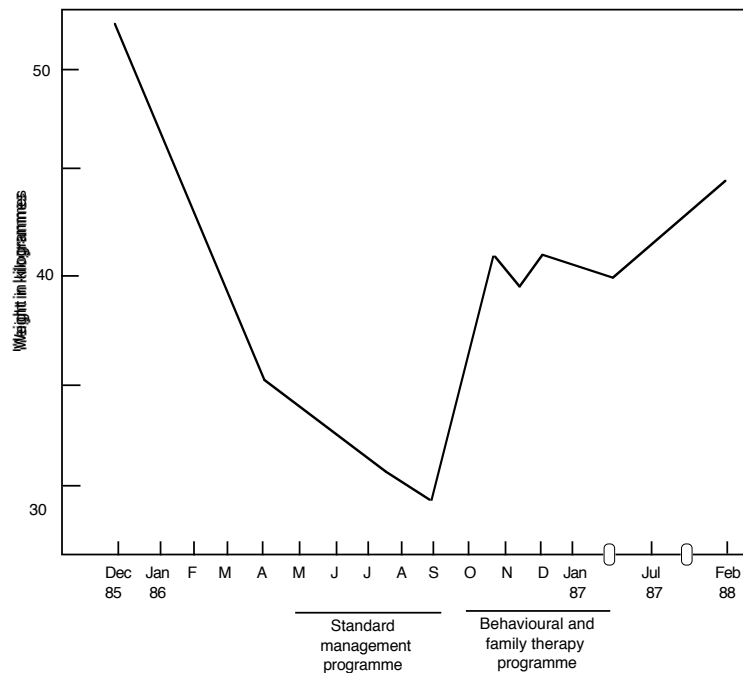
Although 14, he had a bone age of 10 years. His family doctor referred him to the Paediatric Department of our District General Hospital.

The paediatric examination and laboratory investigations revealed no abnormalities. Psychiatric evaluation confirmed a diagnosis of anorexia nervosa and excluded bulimia. Phil showed the following characteristics: 35% weight loss, meticulous dieting, excessive exercise, guilt and depression associated with eating. He expressed a fear of becoming fat again and being mocked at school. There was no evidence of bingeing, vomiting or laxative use.

Phil was treated with a standard management programme. This involved monthly outpatient contact where he would be weighed and the parents instructed on the management of their son's diet and exercise. Hospitalization occurred when significant weight loss was noted. Phil was admitted to the Paediatric Ward for four days in mid-July when he showed a weight loss of 2 kg. He was treated with chlorpromazine, 25 mg bd and Imipramine, 50 mg nocte. The Chlorpromazine was given as sedation to reduce activity and facilitate

weight gain during hospitalization. Phil was placed on antidepressant medication during the period of hospitalization and the trial continued for six weeks following discharge.

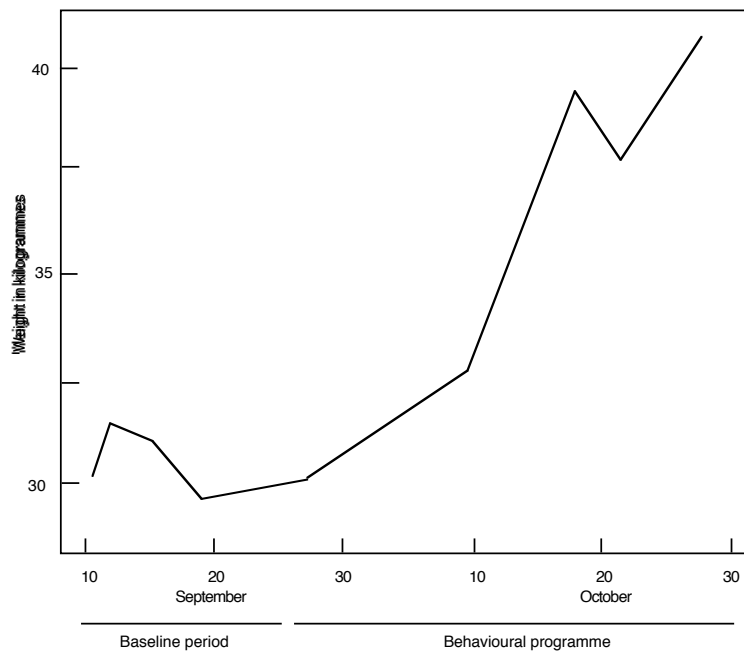
Figure 7.1. Phil's average monthly weight between December 1985 and February 1988.



Between May and September Phil lost about 5 kg (see Figure 7.1). He was hospitalized for the second time on September 28th for a month-long weight gain programme. He was confined to bed under sedation and deprived of normal ward privileges. He was placed once again on antidepressants.

Two days after he was admitted to hospital the Paediatrician referred the case to us. He asked that we develop and implement a ward based behavioural weight gain programme which would allow Phil to earn back his privileges and come off sedation, if we agreed that this was an appropriate method for increasing his weight. In addition, a family evaluation was requested, since the Paediatrician suspected that certain family process might be involved in maintaining Philip's eating disorder.

Figure 7. 2. Phil's weight for the month prior to the individual hospital based behavioural programme and for the month during which the programme occurred .



Behavioural weight gain programme

Before describing the family evaluation and therapy, a brief outline of the weight gain programme will be given. At the start of the programme Phil was confined to bed on 25 mg of Chlorpromazine. His wash basin was covered and sealed and the lower halves of his windows were secured. He was required to use a bed pan for urination and defecation. A target weight of 40 kg, a target diet of three meals per day, and a target three-daily-weight-increment of 300gr. were set by the team. Phil was given freedom to work out with the dietician, the precise contents of the three daily meals. We negotiated a contract with Phil which defined how privileges would be returned for achieving eating and weight targets. The parents consented to the programme. The nursing staff were briefed as to the importance of consistency in the implementation of such programmes.

Four main types of problems arose during the implementation of the programme. First, Phil tried to artificially innate his weight by

retaining faeces or urine. Second, he tried to accelerate weight gain by bingeing on Mars Bars and Complan drink. Third, he tried to misrepresent his weight by manipulating the scales. Fourth, he used arguments about the details of the programme to split the treatment team. The first three difficulties were dealt with by renegotiating the contract with him directly. The fourth difficulty was managed by training the nursing staff in how to monitor Phil's behaviour and dispense privileges in a benevolent but authoritative way.

A graph of Phil's body weight over the month prior to hospitalization and the month he spent on the weight gain programme is presented in Figure 7. 2.

Family evaluation

Family session 1, 9.10.86: Three family evaluation sessions were held while Phil was in hospital. The first was attended by Phil and his parents. Initially the parent's feelings about the evaluation process were explored. They felt guilty, helpless and ashamed for failing to carry out the previous treatment team's instructions and causing their son's further deterioration. They were apprehensive about the proposed evaluation, since it might point to other areas in which they had failed as parents. In view of their self-deprecatory position we defined the family evaluation as a way of assessing how the parents might best help their child avoid relapsing when he returned home.

We then explored explanations different family members had of Phil's anorexia and the solutions entailed by each of these explanations. Four main problem explanations emerged from this discussion.

Mother attributed Phil's food refusal to depression and construed the boy's vulnerability to depression as a characteristic inherited from his paternal grandmother. Poor peer-relationships, in her view, had precipitated his present episode of depression. The treatment advocated by his mother for his depressive state. Talking to Phil about his troubles in a supportive manner was the primary treatment advocated by his mother for his depressive state. When the depression lifted, she expected the eating problem to cease. Mother extended a great deal of energy trying to talk to her son about his depression.

Father, in contrast, described Phil as innately stubborn, like his paternal grandfather. The depression, described by his wife, potentiated Phil's pre-morbid stubbornness. It was the stubbornness that caused him to refuse to eat when asked. To overcome the stubbornness it was necessary to engage Phil in enjoyable activities. Once active and happy, the stubbornness would recede and Phil would eat again.

Father had bought Phil a hunting gun and an elaborate set of tools in an attempt to engage him in shooting and woodwork, but to no avail.

Both parents agreed that the paternal grandfather saw Phil as disobedient. If he were smacked, according to this theory, he would soon begin eating again. The theory had not been tested because Mother saw Phil as too depressed to be smacked.

A final explanation offered by the family was that Phil's behaviour was reinforced by the attention it brought him. If this were the case the solution would be to ignore him. The parents had tried this occasionally, between bouts of talking him out of his depression and actively encouraging him away from his stubbornness.

The parents noted a number of negative effects of Phil's anorexia on family life. First, family mealtimes and outings, once the cornerstone of family life, were now dreaded by all family members. Inevitably, a battle between Phil and his parents would occur on these occasions. Second, Mother's self-esteem as a parent had dropped markedly. Cooking family meals used to give her a sense of pride and satisfaction. Now she dreaded cooking because it reminded her of the rows with Phil. Third, Father worried a great deal more than he used to, because of the way he saw Phil affecting his wife's self-esteem. Finally, both parents now focused all their energy on Phil's anorexia and had little time left for themselves or their marriage.

Despite the severity of Phil's condition and its profound impact on family life, he denied or minimized his symptoms and the parents denied or minimized the family difficulties. The family displayed a number of other characteristics which have been attributed to families with an anorexic child, i.e. enmeshment, overprotectiveness and a spirit of self-sacrifice, rigidity, poor problem-solving, poor conflict resolution and overvaluation of academic achievement (Selvini-Palazzoli, 1974; Minuchin et al., 1978; Garfinkel and Garner, 1982).

We ended the session by affirming the severity of Phil's condition but noting the family's willingness to help in finding a useful solution.

Family session 2, 13.10.86: Only the parents attended this meeting. Phil refused to come on the grounds that his only problem was getting his weight up so the team would let him leave hospital.

The session was used to draw a genogram, take a family history and clarify Phil's developmental history. With respect to the nuclear family, it was noted that Phil had only one sibling, a 15-year-old sister, Sue. She was described as a model child, just like Phil used to be. In looking to the future both parents said that Sue would have little difficulty achieving independence but that Phil was a home-bird and would have difficulties separating from the family when the time came.

The parents contrasted Phil's paternal and maternal grandparents in the following way. The paternal grandparents lived

some way from the family home and had little contact. The maternal grandparents lived nearby and had daily contact. Within the paternal family of origin relationships were emotionally distant. Within the maternal family of origin emotionally close relationships were highly valued and very common among all family members. The paternal family were described as strict; the maternal family as lax. The paternal family solved problems by taking action. The maternal family solved problems by talking. These contrasting features of the two families made it clear why the parents had outlined such contrasting explanations of Phil's difficulties in the previous session.

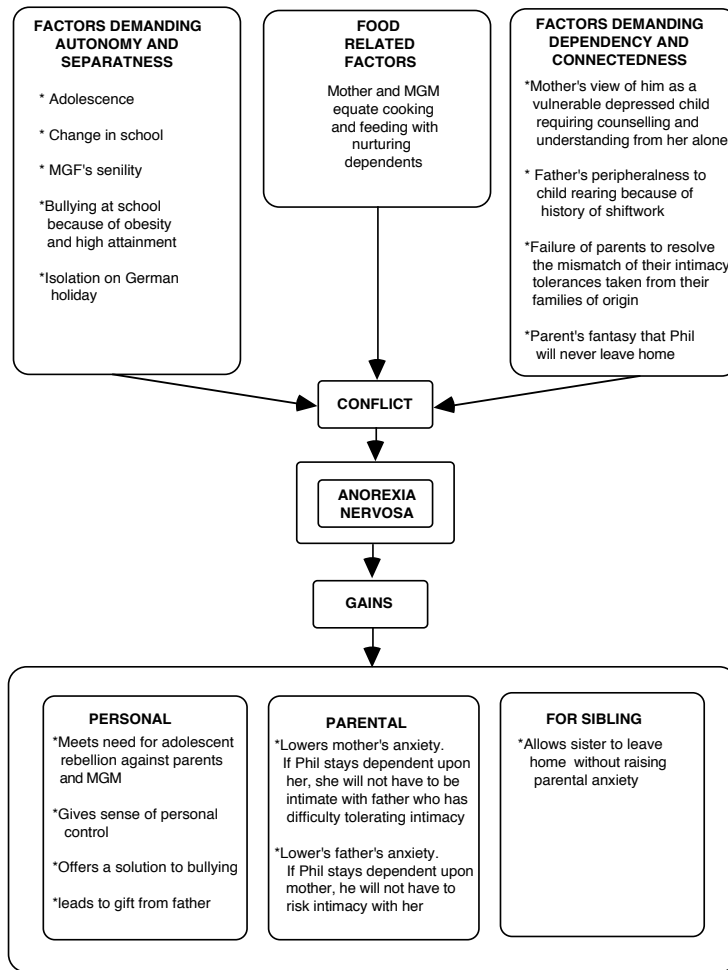
A number of important items concerning the maternal family of origin were noted. The maternal grandmother had been depressed all her daughter's life. Mother had helped her mother with the depression by talking to her for hours on end about her problems. In 1983 the maternal grandfather had become senile. Caring for him, had helped the maternal grandmother with her depression. One of the first signs of the maternal grandfather's senility was food refusal. Phil was the maternal grandmother's favourite grandchild. She was a great cook and used to show her love for Phil by cooking special dishes for him.

The child's developmental history revealed that Phil had been born by caesarean section and was a poor sleeper for his first 18 months. While his psychological development had been normal, he was always small for his age. These factors led mother to view Phil as vulnerable and in need of protection. Like the maternal grandmother who had no sons, Phil's mother prized him as the first male child of the family in two generations. The result was the development of a highly enmeshed, overprotective relationship.

Father worked night-shifts during much of Phil's life. This resulted in him becoming gradually more peripheral to the exclusive mother-son relationship in particular, and family life in general, over the years. In primary school Phil had been a model child showing good adjustment both inside and outside the classroom. In his first two years in secondary school, his teachers began to acknowledge that he had outstanding abilities. However, this got him a poor name among some school bullies who mocked him for being *brainy and fat*. It was their jibes that had precipitated his first bout of dieting.

He began to diet sensibly at first. Then he went to stay with a German family for a couple of weeks. The family placed little emphasis on food. Both of the parents worked full time and left Phil and their son to prepare their own meals. The boys had a disagreement and Phil became quite homesick and would ring his mother daily. It was at this point that he began to diet in an extreme way. He continued to lose weight steadily from that point onwards.

Table 7.1. Formulation outlining factors contributing to the genesis and maintenance of Phil's anorexia nervosa



Formulation: A formulation, based on the assessment described above, is presented in Table 7.1. The formulation indicates that Phil was caught between two sets of demands: one for autonomy and the other for dependence. Coming from a family where food symbolized dependent nurturance, restrictive eating offered him a solution to his dilemma. It provided him with an arena for adolescent rebellion. It allowed him to take control of his life and reap a variety of

personal gains. It also enabled him to reduce anxiety his mother might have about him growing up and leaving her. This anxiety was founded in his mother's view of him as a vulnerable child. Once he stayed anorexic he would not have to leave home. His illness also took pressure off his father to be close to his mother. Father had a low tolerance for intimacy because of the emotional distances which characterized the relationships in his own family of origin. Finally Phil's symptoms ensured that his sister, Sue, could safely leave home.

This formulation draws on explanations of anorexia offered by systems theory (Selvini-Palazzoli, 1974; Minuchin, 1978) behavioural psychology (Kellerman, 1977; Garner & Bemis, 1982) and ego psychology (Bruch, 1973).

Strategies and goals: Our overriding strategy was to try to change Phil's perception of his parents as demanding that he stay dependent. If he could see them as accepting the inevitability of his autonomy, then his conflict would be resolved and the anorexia would no longer be necessary. A number of subgoals were identified within the context of this overall strategy: (1) to help Phil to see his parents as a united couple who could survive without him; (2) to decrease the enmeshment between Phil and his mother; (3) to move the focus of parent-child exchanges away from food and onto normal adolescent issues such as limits, relationships, achievements and pastimes; (4) to coach the parents in managing normal parent-adolescent conflict and (5) to encourage Phil to engage in normal peer relationships, leisure activity and academic pursuits.

Family session 3, 24.10.86: Both parents and both children attended this session on the ward. Phil had reached his target weight and the team had agreed to discharge him after the session. We presented the formulation and empathized with each family member's role in this way of framing the problem. We then suggested the following tasks which would alter family life so as to minimize the probability of Phil relapsing. First, Phil and his parents should avoid talking about food and dieting. Second, we acknowledged that Phil may have got the mistaken idea that his mother needed to talk to him a lot for personal reasons, whereas the truth was that she did not. She only did this, we said, to try to get him out of his depression. We suggested he make a sign for his room which said *Mum can look after herself*. Third, we acknowledged that mother would find it difficult to avoid talking to Phil about food and his depression because of her habit of regularly doing so. We advised that she take some time each evening when she could share her anxieties about Phil with her husband. Finally, we advised that Phil be responsible at home for his own eating behaviour and weight. A separate and private arrangement would be made by the team with Phil to come to the clinic to have his weight checked. Consequences for

weight loss would be worked out privately between Phil and the team. After some clarification the family agreed to do these tasks and the parents accepted an offer of a follow-up appointment in a few days.

Treatment Programme

Crisis phone call, 29.10.86: The day before this crisis call we phoned Phil to give him details about having his weight checked at the clinic. Father, who made the crisis call, said that after the phone conversation, Phil became moody and annoyed. He said his illness was over and he wanted no more contact with the hospital. The next morning he became openly defiant and ran into town before finishing breakfast. The parents chased him in the car. From time to time Phil would make himself visible to them and then duck back into hiding. In the end they gave up the chase. Both parents were very upset.

Father then went on to deny the validity of the family evaluation, question the value of family therapy and frame Phil's eating difficulties as an individual problem. He said *We don't need marriage guidance, which is what you're offering. Our son is mentally ill and needs expert help in a special unit!*

A number of issues were probably leading father to reframe Phil's eating difficulties as an individual problem. Father's involvement in a game of cat and mouse with Phil in full view of the neighbours had left him feeling humiliated and angry. In his anger he could only define his son's behaviour in one of two extreme ways: as *bad* or *mad*. If Phil's behaviour was *bad*, he was completely responsible for it and therefore had managed to make a fool of his father. This position was unacceptable because it violated father's self-image as a competent and respected parent. Also, if Phil were *bad* he would have to be punished. Mother would have objected to her husband doing so and he feared involving himself in disagreements with her because the couple were poor at conflict resolution. So, instead father saw his son as *mad* and therefore not responsible for his behaviour. If his son were *mad* he could only be *cured* by experts. Thus, father was absolved the responsibility of dealing with his son's relatively normal rebellious adolescent behaviour.

Rather than become embroiled in debates about individual and family models of anorexia nervosa we offered father the following *expert advice*. He and his wife should go home and stop chasing Phil. If after 12 hours (8.00 pm) Phil failed to appear, then the police should be informed and a proper search conducted. Father agreed to bring Phil to the session that was scheduled for the parents for two days time.

Family session 4, 31.10.86. We believed that Father in particular had found the first crisis very threatening and required a lot of support if he were to continue being involved in family treatment.

However, he resented being given such support in front of his son. Also, as we found out in session 1, his view of his son's difficulties was quite different from that of his wife. We guessed that he would be reluctant to expose his feelings about their differences in her presence. In the light of these considerations we decided to see the family members for separate interviews initially, and then for a conjoint family meeting. SA interviewed mother. AC interviewed father and subsequently Phil.

Father began by acknowledging that our advice on how to handle Phil's runaway escape had been useful. He said that Phil came home for lunch at 2.30 and spent much of the rest of the day alone in his room. We admired his courage in following such difficult advice.

Father revealed his 'true theory' about Phil's eating disorder. Ever since Phil had been a toddler he had engaged his mother in battles. Various arenas were used. For example Phil might express an extreme view to his mother about a television programme and goad her into arguing the opposite position. His food refusal was another one of these battles. Inevitably Phil beat his mother in all of these battles and she would withdraw feeling sad and dejected. When father saw his wife in this state he would feel both angry at Phil and sad that his wife had been viciously hurt by Phil. He said he felt powerless to stop them having these battles. His wife always fell into the traps that Phil set and she disapproved of father chastizing Phil about these matters. Father desperately wanted the battles between Phil and his wife to stop.

Information from the interview with mother revealed that she felt inadequate, especially when Sue, her daughter, looked after Phil by cleaning his room or making him meals. She was unaware why she became involved in battles with Phil. However her reluctance to punish him for them stemmed from a fear she had that he might try to kill himself. This fear arose from experiences with her own depressed mother who had made suicidal threats and gestures when she was a child. Phil said that the battles always ended in his mother withdrawing and so were a way of getting some breathing space away from her. He said he wanted his parents to back off and give him some room to grow. In the family meeting which followed the individual interviews we relayed this information to the three family members. All of them looked relieved. Little discussion or clarification was required.

The following homework arrangements were made. Mother agreed to try to cut down on her contact with Phil. Father agreed to be completely responsible for child care for those times in the next week when he was not at work. Phil agreed to be more assertive about his privacy.

The parents agreed to attend four further sessions. Phil declined an offer of concurrent individual work. He reluctantly agreed to continue to attend the clinic for weight checks.

Family session 5, 6.11.86: The parents reported that a second crisis had occurred. Phil had refused to eat supper and father had physically chastized him. Phil, in response, locked himself in his room until the next day. Mother supported her husband wholeheartedly and called the family doctor who visited and gave father some sleeping medication. Thus, the crisis led to a weakening of the cross-generational coalition between mother and son and a strengthening of the parental alliance. The next day the parents made arrangements for Sue to stay with an aunt for a couple of weeks until the end of her school examinations. They did not want their difficulties with Phil to interfere with her academic achievement.

After the crisis, Phil insisted that other family members respect his privacy and not enter his bedroom uninvited. He also joined an amateur dramatics group.

The parents were congratulated on the way they handled the crisis. We predicted three or four more crises would occur over the next six months and that they needed to have a plan prepared for handling them. We advised that in each crisis, one parent take responsibility for dealing directly with Phil and the other be available afterwards to support the parent who had dealt with the crisis. We suggested that they alternate roles from one crisis to the next. We ended the session by facilitating the parent's rehearsal of dealing with Phil after he had stolen some money and run away for a few days. We asked them to phone for an appointment after the next crisis.

Family session 6, 26.11.86: The session opened with the parents account of the third (and final) crisis. It began when Phil received a letter from the team containing a list of dates on which he had to attend the clinic to be weighed. He had been missing almost every second weight check appointment. The letter stated that he needed to complete a sequence of four weekly weight checks successfully before their frequency could change to once a fortnight. After four of these, he then needed to be weighed once a month for two months.

Having read the letter he ripped it up, in anger, and bolted out of the house. As in the case of the first crisis, the parents chased him by car but decided to terminate the search after an hour. In the afternoon he instructed them, by phone, to bring his sports gear to a designated spot in town. He wished to attend a body building club which he had recently joined. They collected him at the agreed meeting place and by force, brought him home where father once again physically chastized him. Mother supported her husband and called the family doctor who came and spent an hour talking to Phil. The doctor supported the parent's for *taking a firm stand* with Phil.

Father said that he felt he needed some way of asserting his

parental authority without smacking his son. We invited the parents to draw up a list of alternatives and decide on which of these they would feel comfortable using. They found the task quite difficult because the main options involved withdrawing privileges from Phil. This seemed cruel to them. They settled on sending him to his room with holding back pocket money as a backup.

The parents had difficulty connecting the three crises with Phil's original symptoms. Once again, we presented our formulation and described anorexia nervosa as an adolescent's battle for independence with food as the battle arena. Since Phil could no longer fight with his parents about food, because this issue was now dealt with directly by the team, his battle for independence had to find expression elsewhere. We described his running away as a request for more freedom and his locking himself in his room as a request for more privacy. We defined both, as normal adolescent behaviour which could best be dealt with if the parents and son could find a way to openly negotiate about these matters.

Family session 7, 16.12.86: The parents gave the following account of their son's social adjustment for the three-week interval which had elapsed since the previous session. Phil continued to attend amateur dramatics and the body building club. At school he was top of the class and captain of the school quiz team. He had been involved in one altercation with a bully and he stuck up for himself, something he had never done at secondary school. He had gone to his first disco and had met his first girlfriend who he had now been seeing daily for two weeks.

We congratulated the parents on the work they had done to help Phil achieve this new independence. We cautioned against relapses at times of stress. They told us that they would handle such relapses by allowing Phil privacy and avoiding battles over food. Because we had never fully dealt with Mother's fantasies about her son's potential for suicide, we assured her that if she ever had evidence that he might injure himself, we would admit him to the paediatrics ward immediately and without question. She was confident that her fears were really unfounded. In view of Phil's improvement the antidepressant medication was gradually withdrawn after this session.

Family session 8, 16.3.87: This final session was attended by the parents only. Phil's excellent social adjustment continued. He had withstood three sizeable life stresses without relapsing. First, at Christmas his maternal grandfather had died. Second, he had gone to Germany for a two-week holiday similar to the one which precipitated the onset of anorexia nervosa. Third, he had ended his first romance which lasted for a couple of months. Both parents commented that they found themselves spending a lot of time alone together. They were

enjoying watching their children become independent and took vicarious pleasure from the children's social and academic conquests. However they also missed the enmeshment and home-centredness of pre-adolescent family life. The team initially thought that Father, in particular, would find this *forced intimacy* quite threatening. These fears were unfounded. The couple's marital satisfaction had increased over the course of treatment.

Crisis phonecall, 3.7.87: Four months later Mother phoned to say that her husband had been forced by his employer to change jobs. His new job was of a lower status and so he had suffered a major loss of self-esteem. Phil had responded with moodiness and food refusal which had lasted 48 hours. Mother was sure he was going to relapse and she was in a state of panic. After clarifying the facts and empathizing with mother's position, the following interpretation was offered. We suggested that Phil felt responsible for cheering up his father, but powerless to do so except by becoming ill again. This would force father to overcome his depression and involve himself in the care of his son. If mother attempted to talk her son out of his present state she would in fact be re-establishing the original pattern of family interaction. We cautioned against this approach. If, however, she demonstrated to her son through her actions, that she could support father through this crisis and that his help was unnecessary, then he would probably not relapse. We advised her to set *private time* aside for herself and her husband which they should spend away from both the house and the children. During these periods she should be maximally supportive of her husband. The children should be informed that the parents are having *private time* together, but the details should be kept a secret from them.

Mother thanked us for the advice and said that she would contact us only if the intervention was ineffective. She also asked that we keep the conversation confidential from her husband.

Follow-up phonecall, 10.12.87: When we called the family about five months later Father said that he had settled into his new job and was feeling a lot better. He mentioned Phil's brief relapse but said that he was now fully recovered and was planning to go away to college in the near future. Father was unaware of our telephone conversation in July with his wife but offered the following spontaneous comment which suggested that Mother had complied with the directives that had been given during the crisis telephone call: *I couldn't have made it without my wife. I got really down but she used to make me go out with her and pulled me out of it.*

Phil was last weighed at the clinic in February 1988 and had attained a weight of 45.4 kg (see Figure 7.1.).

DISCUSSION

That factors other than the therapy described in this paper may have been central to ameliorating Phil's eating disorder seems unlikely. Figures 7.1 and 7.2 show that during the standard management programme, Phil's weight decreased whereas from the onset of behavioural and family therapy programme his weight increased markedly.

A family's capacity to weather crises without symptom recurrence is one criterion for successful therapy. By this standard, the therapy described here was effective (since Father's demotion four months after the termination of therapy was a major family crisis). Structural changes within the family were associated with this improvement in family functioning. Over the course of therapy, the intergenerational boundaries became more clearly defined and the parental alliance strengthened. Alongside the improvement in family functioning and the change in structure, Phil resolved his developmental conflict in that he achieved a marked degree of autonomy and was able to contemplate leaving home.

The treatment described in this paper has a number of features which might fruitfully guide the management of cases where young adolescents present with physical complaints other than anorexia nervosa. These include: (1) close co-operation between the paediatrician and the family therapy team; (2) behavioural and/or medical treatment of symptoms on an inpatient basis and concurrent family evaluation; (3) the development of a comprehensive formulation which can be presented to the family as a rationale for homework tasks given just before the adolescent is discharged from hospital. The tasks should facilitate the establishment of a strong intergenerational boundary between the adolescent and the parents; (4) separate sessions (or therapists) should be allocated to the adolescent and the parents as a way of modelling and reinforcing the intergenerational boundary; (5) the symptom should be monitored by the adolescent's therapist and discussion about the symptom between the adolescent and the parents should be prohibited; (6) the parents should be advised that they will be supported by the team when they become involved in inevitable battles with their adolescent about freedom and privacy; (7) when crises occur, the parents' therapists should provide immediate support for them and use these occasions to teach parent/adolescent negotiation and limit setting skills; (8) cases should be followed up until the family have successfully dealt with a major family stress and demonstrated the capacity to cope without a serious relapse.

REFERENCES

- Beaumont, P., Beardwood, C. & Russell, G. (1972). The occurrence of the syndrome of anorexia nervosa in male subjects. *Psychological Medicine*, 2, 216-231.
- Bruch, H. (1973). *Eating Disorders*. New York: Basic Books
- Bryant-Waugh, R. Knibbs, J., Fosson, N., Kaminski, Z. & Lask, B. (1988). Long term follow up of patients with early onset anorexia nervosa. *Archives of Disease in Childhood*, 63, 5-9.
- Fosson, N., Knibbs, J., Bryant-Waugh, R. & Lask, B. (1987). Early onset anorexia. *Archives of Disease in Childhood*, 62, 114-118.
- Garfinkle, P. & Garner, D. (1982). *Anorexia Nervosa: A Multidimensional Perspective*. New York: Brunner/Mazel.
- Garner, D. & Bemis, K. (1982). A cognitive behavioural approach to anorexia nervosa. *Cognitive Therapy and Research*, 6, 123-150.
- Jacobs, B. & Isaacs, S. (1986). Pre-pubertal anorexia nervosa: A retrospective controlled study. *Journal of Child Psychology and Psychiatry*, 27, 237-250.
- Kellerman, J. (1977). Anorexia nervosa: The efficacy of behaviour therapy. *Journal of Behaviour Therapy and Experimental Psychiatry*, 8, 387-390.
- Minuchin, S. Rosman, B., & Baker, L. (1978). *Psychosomatic Families: Anorexia Nervosa in Context*. Cambridge: Harvard University Press.
- Russell, G., Szmukler, G., Dare, C., & Eisler, I. (1987). An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Archives of General Psychiatry*, 44, 1047-1056.
- Selvin-Palazzoli, M. (1974). *Self-starvation*. London: Chaucer.
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