

The Maudsley Model of Family Therapy for Children and Adolescents with Anorexia Nervosa: Theory, Clinical Practice, and Empirical Support

Paul Rhodes

The aim of this paper is to present the Maudsley model of family therapy for children and adolescents with anorexia nervosa, one that integrates principles and skills from a variety of models. The Maudsley model is of prime importance because of its non-pathologising approach to families, because its techniques have been published in sufficient detail for standardised application by clinicians, and because of its strong history of empirical support. It is also a model that integrates both modernist and constructivist influences from the history of family therapy.

Family therapy has shown a strong interest in anorexia nervosa ever since its origins as a treatment modality in the 1970s, with Minuchin (Minuchin, Rosman & Baker, 1978), Selvini Palazzoli (1974), and White (1987) all developing rich theoretical and practical approaches to the disorder. This paper will describe the Maudsley model of family therapy for anorexia developed by Christopher Dare and colleagues at the Maudsley Hospital in London (Dare, 1985) and recently published in manual format (Lock, le Grange, Agras & Dare, 2001). This model integrates principles and skills from many of the major schools in family therapy and is suitable for adolescents where there is less than three years duration of anorexia nervosa.

Theoretical Foundations

Early work at the Maudsley hospital was strongly influenced by Minuchin and Palazzoli's ideas regarding the aetiology of anorexia (Dare, 1981). Families were seen as dysfunctional in that they were rigidly organised, with the anorexia performing the function of maintaining homeostasis in the face of the adolescent life-cycle stage. Interactions were seen as being guided by intergenerational coalitions, enmeshment, and the lack of conflict resolution. Minuchin took a very active role as a therapist, guiding the parents to take charge of their child's eating and therefore inviting them to change the structure of the family. Joint effort by the parents reinforced the boundary between marital and sibling-subsystems. The

tough stance taken by the parents prevented conflict avoidance and required them to become less enmeshed with their child. Palazzoli took a less active and more neutral stance, breaking patterns of interaction by introducing news of difference regarding the function of the symptom, and prescribing tasks such as the secret couples task (Selvini Palazzoli, 1986) to modify the generational boundaries and facilitate the adolescent's individuation.

By 1987, however, Dare and his colleagues had come to question the view that family dysfunction was responsible for anorexia (Dare, Eisler, Colahan, Crowther, Senior & Asen, 1995). Russell, Szmukler, Dare & Eisler (1987) conducted a clinical trial with eighty patients suffering anorexia, comparing family therapy with individual therapy. They found that family therapy was far superior with patients under eighteen years whose illness was less than three years in duration, but that individual therapy was superior for patients over eighteen years of age. Clinical observations confirmed the view that families are organised and structured in remarkably similar ways, and that response to family therapy was determined by illness factors, particularly the age of onset and the duration of the illness. The family life cycle was seen as less important than might have been predicted, given that families of patients under and over eighteen years all displayed similar clinical characteristics.

These findings helped to confirm a theoretical stance in the Maudsley model that has its origins in Haley's (1973) strategic model of family therapy, namely its strong agnostic view of the aetiology of psychological disorders. Given this view, the illness could be 'placed' outside of the family, thus being framed as independent of family functioning.



Paul Rhodes, Clinical Psychologist, Department of Psychological Medicine, Children's Hospital at Westmead, NSW. Address for correspondence: 42 The Sanctuary, Sanctuary Gardens, Westleigh, NSW 2120 Australia. Email: paulr2@chw.edu.au

It is no coincidence that Michael White was influenced by strategic family therapy in his development of the technique of externalisation. The Maudsley model included this strategy with the aim of breaking cycles of parental guilt and resulting criticism of their child. The anorexia (rather than any family members) is personified as the oppressor, and its influence on the family is mapped. Parental guilt can be perceived as another 'trick' of the anorexia. The parents can then be freer to take charge of the anorexia in the relative absence of criticism of the child. Very firm and insistent stands can be taken while maintaining the adolescent's need for autonomy. In this sense, the Maudsley model was able to embrace the influence of Minuchin's structural work with anorexia, and also respond to the criticism that it is an approach that allows clinicians to see families as deviant or pathological (James & MacKinnon, 1986). The potential of structural work is enhanced by placing the deviance squarely on the shoulders of the illness.

Post-Milan ideas were also influential in that the clinician no longer gave the parenting team specific instructions regarding refeeding techniques or goal weights. The influence of second-order cybernetics (Hoffman, 1985) allowed for the co-creation of strategies in place of the more authoritarian structural position. Parents were encouraged to rely on their own expertise in these matters and were perceived as a resource for the patients' recovery rather than the cause of the illness.

Stages of Treatment

The Maudsley model sets out three clear phases of intervention (Lock et al., 2001). In the first phase, treatment focuses exclusively on the refeeding of the patient, and other psychological issues are not explored. Refeeding implies that the patient is under weight but some may have been recently discharged from hospital after nasogastric feeding and therefore be much closer to their ideal body weight. An emphasis on refeeding is still required for this group, however, given high readmission rates for anorexia nervosa (Meads, Gold & Burls, 2001) and the likelihood of relapse in the home setting. Parents are encouraged to set their own goals regarding their child's weight and health, with an emphasis on physical appearance and menstruation in girls as an indicator rather than precise weight goals.

This phase includes a picnic in the therapy room, and three to ten or more sessions focused on the refeeding process. The second phase (two to six sessions) includes this refeeding task but also gradually hands responsibility for eating back to the patient. Consideration of adolescent individuation is included only when it is a question of eating out with peers or on dates. In the third phase (approximately four sessions) eating is handed over more completely to the adolescent and there is more direct exploration of individuation, and the adolescent's relationship to the parents. Phase two commences once the adolescent is at 87% of her ideal weight, and the parents feel some relief at being able to take charge of 'the

anorexia'. Phase three commences once the parents feel she has achieved a healthy weight, including the commencement or return of menses.

Phase I: Refeeding the Patient

Initial Evaluation and Setting Up Treatment

First contact with the family is made during the patient's admission to hospital. At this point, the patient is medically compromised and refeeding is conducted by medical and nursing staff. The adolescent and the parents are interviewed separately and basic diagnostic questions are asked. Children who are malnourished because of conversion disorders, food phobias, or obsessive compulsive disorders are excluded from the Maudsley model of treatment. Children with a history of sexual abuse are not excluded if the perpetrator is not living with them. Self-starvation is regarded as having a higher treatment priority than sexual abuse, given the risks to the child, and the treatment of trauma is left until the final phase of treatment.

The family is contacted by phone and by letter to set up treatment just prior to or just after discharge from hospital. These communications are made in a sincere but grave manner, and the therapist aims to impress on the parent that there is a still a crisis in the family that could take their child's life. Each member of the family is requested to attend so that they can begin to fight 'the anorexia'.

The First Family Meeting

This first meeting is of crucial importance in engaging with the family and mobilising their sense of responsibility for refeeding their child. The therapist aims to create a therapeutic double bind by simultaneously empathising with the external effect that 'the anorexia' has had on the parents and their children, and simultaneously charging them with the task of refeeding. The first step is to employ circular questions to explore the effects of 'the anorexia', with particular reference to any invitations it may have given to the parents to blame themselves. Family members can be encouraged to argue against the parent-blaming view that is held by the illness. The therapist also encourages the family to separate the patient from the illness by stressing how little control the patient has over these behaviours, and how it has gradually overtaken her. This can be done by asking family members to rate how much control they feel the anorexia has over the patient and how much control the patient has over the anorexia (White, 1988). Features of anorexia, such as distorted concepts of body image, food-related anxiety, and water-loading before weigh-ins may also be framed as 'tricks that the anorexia has gradually employed' to take control of the patient. The technique of collapsing time (White, 1986) is then used to create an intense scene regarding the possible medical effects of prolonged illness. This is an important focus, given that anorexia has the highest mortality rate of any psychiatric illness at 6–15% (Steinhausen, Rauss-Mason & Seidel, 1991; 1993). There

are also risks of permanent growth retardation, osteoporosis, cardiac dysfunction, and structural abnormalities in the brain (Fischer, Golden, Katzman, Kreipe, Rees, Schebendach, Sigman, Ammerman & Huberman, 1995). The parents are then encouraged to take two weeks off work to start the refeeding process, and the adolescent is asked to take two weeks off school. The message the parents are left with can be summarised as 'It is definitely not your fault, but it must be your responsibility'.

The Family Meal

At the next session, the parents bring in a picnic for the family. The parents are asked to take charge of 'the anorexia' and get their daughter to eat one more mouthful than she wants to. They are observed in this process, as are the siblings. The therapist aims to interrupt any family structures that erode parental authority, including inconsistency between the parents, and sibling attempts to help. The role of the parents is to be a monotonous voice insisting that their daughter eats. Specific ideas and strategies are left to the parents, but they are discouraged from negotiating and discussing calorie intake with their daughter. The siblings' role is to watch their sister to see when she gets distressed by her parents' attempts. They are to form an alliance with her and comfort her, but not to join the parenting team. During the meal the therapist also asks about any ground that 'the anorexia' may have taken regarding specific foods in the house. The parents are asked to review their shopping and mealtime arrangements in the light of what they feel would be needed to feed their starving daughter. Specific nutritional advice is avoided and parents are asked what their instincts tell them is right.

On some occasions, the adolescent will comply readily with the parents' attempts in order to ease their stress at having to perform in the therapy room. In this situation the therapist asks the adolescent to resist her parents' attempts to control anorexia so that her vitality and autonomy is not jeopardised, and so that the parents can be given some practice at fighting the illness.

Continued Focus on the Refeeding Process

For the next three to ten or more sessions, the therapist continues to focus exclusively on the refeeding process. Successes and difficulties with this task at home are reviewed in detail, and discrepancies are clarified using circular questions. Particular attention is paid to reinforcing the different roles of the parenting and sibling subsystems. Criticism of the patient is monitored very closely and modified at each occasion. Criticism or emotion expressed (EE) by the parents is considered to be a result of projected self-blame and is addressed primarily by reminders about 'the anorexia' (not family members) being to blame. Parents can be referred at this point for individual support if clinical depression, anxiety, or other forms of psychological disturbance serve as restraints on the refeeding process.

Phase II: Negotiating for a New Relationship

This phase serves to facilitate a transition between the focus on refeeding and exploration of more generic adolescent-family issues. The parents are still encouraged to refeed their daughter, but the therapist coaches them less and assists them to be confident in their own expertise when there are difficulties. The therapist facilitates careful negotiations between the parents and the adolescent so that she can gradually take more responsibility for her own mealtime behaviour. Peer relationships and sexuality are also explored, but at this point only in reference to food. If socialising or dating is resumed, for example, the emphasis remains on the patient's management of eating outside of the house rather than on the relationships per se. Careful plans are made for with the patient regarding eating when out with friends or on dates. Phase one is revisited if increased autonomy threatens continued weight restoration.

Phase III: Adolescent Issues and Termination

This phase is commenced once the adolescent reaches 90–100% of her ideal weight and has control over her own food intake. The focus is taken off the refeeding process, and adolescent individuation is explored in detail for the first time. This is deemed possible because structural restraints to individuation have been dealt with indirectly in Phases I and II, and necessary because anorexia has prevented the patient from making the transition through this developmental stage. A wide variety of adolescent issues are explored and worked through with the family, including separation, peer relationships, and sexuality. The parents are also encouraged to give up attitudes and skills that were appropriate at earlier stages in their child's life and to spend more time together as a couple. The aim of this stage is not to embark on fully-fledged family therapy for the adolescent or to instigate couple therapy. If problems between the couple persist, a referral for marriage counselling is recommended. This remains an option given that a stronger parenting team does not always necessarily lead to the resolution of marital issues.

Liaison between the Lead Therapist and Other Professionals

While the therapy is essentially conducted by one family therapist, the need for careful liaison with other professionals is paramount in this model. Firstly, it is advisable for the therapist to seek regular weekly supervision. The model is particularly challenging because it draws on theories and techniques from a variety of approaches to family therapy and also because working with anorexia can often be an exhausting and prolonged process. The therapist may have to rely on a supervisor's support to maintain persistence and confidence in the face of drawbacks, and also to review regularly his/her technical proficiency and understanding of the family dynamics at play. Each therapist conducting the Maudsley model is expected to be trained as a generic

family therapist, and also to have received some training in the model. Supervision needs, however, depend on the therapist's level of experience.

It is also vital that the therapist meets regularly with the medical treatment team, including psychiatrist or paediatricians, and dietitians. Most outpatients still see the hospital treatment team regularly, and it is vital that the whole team have a clear understanding of the Maudsley treatment philosophy. The therapist is encouraged to make weekly e-mail or phone contact after each session. Liaison with the medical team is obviously also vital if the patient is becoming medically compromised and requiring readmission. Contact of this sort will be easier for family therapists working in the same facility as the medical team. Therapists working in community settings or privately can still use the model, but they will need to foster close working relationships with the relevant medical personnel.

Modifications in the Case of High Expressed Emotion

One concern for Maudsley clinicians after the Russell et al. (1987) trial was the family therapy drop-out rate (15 of 41 patients). In further analysis of the data from this trial, Szmukler, Eisler, Russell & Dare (1985) found that drop-out cases could be clearly predicted by parental criticism of the adolescent as measured by Expressed Emotion ratings (Vaughn & Leff, 1976). Le Grange, Eisler, Dare & Russell (1991) conducted a further study in an attempt to explore possible modifications of the Maudsley model so that drop-outs might be decreased in the clinical setting. In this study, the standard Maudsley treatment, labelled 'conjoint family therapy', was compared to 'family counselling' where the patient and the parents were seen separately. In the latter group, therapy followed similar phases, with refeeding taking precedence over other issues until the patient's health was restored. The parent meetings focused on the refeeding task, while the aim of the individual meetings was for the therapist to empathise with the pain experienced by the adolescent due to the change in the parent's approach. Findings showed little difference in efficacy between the two models, but did suggest that family counselling was more effective for families with high expressed emotion. The conjoint therapy was considered to be too confrontational for this group and might contribute unnecessarily to drop-out in the clinical setting.

Case Vignette

Sally Wong is a thirteen year old girl admitted to hospital for the first time, with a weight of 32.9kg and a body mass index of 13.82. She was medically compromised with bradycardia (slow heart rate), hypothermia, and protein calorie malnutrition, including muscle wasting and poor peripheral blood flow. She was admitted for a total of eight weeks and commenced on overnight nasogastric feeds and a supervised menu plan during the day. She remained on bed rest for the first three weeks, and after five weeks graduated

to supervised menu plan only. She attended the hospital school during her admission, as well as physiotherapy, and recreational group programs. Family and individual meetings in the hospital were limited to diagnostic screening, psychoeducation, and general support. These in-patient meetings were not conducted by the therapist responsible for her outpatient family therapy. Sally's discharge weight was 35.8kg.

Sally's family consists of her father, Winston, who works as a caretaker, her mother Leanne, who works part-time as a secretary, and her brother Michael, who is eight years old. The family is of mainland Chinese origin and immigrated to Australia thirteen years ago.

Phase I: Refeeding the Patient

Setting Up Treatment

The therapist's first contact with the family was by telephone. The therapist introduced himself and explained his role as helping them with Sally's recovery once she was discharged from hospital. The family was then sent a short letter that reiterated points from the telephone conversation.

Dear Mr and Mrs Wong,

It was good to speak with you yesterday on the telephone to make an appointment for our first family meeting to help you with Sally who is suffering from Anorexia Nervosa. I am particularly concerned about how she will progress once she is discharged from hospital and believe that you will be incredibly important in helping her to return to health. As we discussed, Anorexia Nervosa has the highest mortality rate of any psychiatric illness. We will all need to work extremely hard to make sure that she can recover.

It is very important that every member of your family come to our meetings at the hospital. Each of you will have been affected by the anorexia and each of you will also have something important to offer, in standing up to the grip it has had on the family. It may be difficult at times for all of you to attend, but it is vital given how extremely vulnerable your daughter is at the moment.

I look forward to meeting you all at 1:00 in the Medical Centre. Could you please come fifteen minutes early so that our nurse can weigh Sally before we meet.

Yours sincerely,

The First Family Meeting

In the first family meeting, the parents described the effect that the anorexia had had on them since its onset six months ago. Both described how distressed they had been by her admission to hospital, but also expressed some relief due to feeling that they had not known how to help her at home. Winston was eager to point out that he felt Leanne was responsible for the severity of Sally's illness because she had been less prepared to accept the illness than he. Further circular questions revealed that Winston's criticism of his wife was also related to his own guilt regarding the illness. Both parents were found to be united in blaming themselves and this was framed by the therapist as one of the anorexia's

manipulative tricks. Further questions were used to extend this process of externalisation to Sally. The anorexia was seen as more in control of Sally than vice versa. The anorexia was described as having been successful in deceiving her into seeing herself as fat, and also at getting her to drink water before her initial weighings at her General Practitioner's surgery. No exercising was reported. Michael was observed to be actively involved in reporting on Sally's behaviour, and Sally said that he often did this at home. Sally angrily stated that it had had a negative effect on their relationship. The therapist then summarised the session so far, taking great pains to empathise with the family's suffering over the past six months.

The family was then asked what effect the anorexia would have on Sally if it continued to take charge over the next twelve months. Winston and Leanne described how her growth might be stunted and how her reproductive system might be damaged. The therapist described other possible medical complications as well as the risk that it could kill her. The family was visibly shocked by this, but the parents still stated that they would do whatever was possible to help her. The session was then summarised and the family was charged with the responsibility of standing up to the illness. The therapist expressed his firm belief that they were the best resource for this purpose. Arrangements were then made for the next session, the family meal.

The Family Meal

This session was held at 12.30 p.m. to coincide with lunchtime. Leanne brought ham sandwiches, fruit, and orange juice from home, and Winston brought a large serve of noodles and vegetables that he had purchased near his workplace. The parents were asked to attempt to get Sally to eat one more mouthful than she wanted to. Sally was also asked to resist their attempts so that they could gain some practice in taking charge of the illness. Michael was asked not to join his parents but to watch out for any signs of distress in Sally.

During the early stages of the meal, the therapist asked the family questions about eating habits at home. Sally and Michael typically ate breakfast on their own, while Leanne made school lunches and Winston got ready for work. Winston was rarely present for dinner, but the remaining family members sat together. Sally was reported to eat the same food as the rest of the family, but in smaller quantities. Further questions, however, revealed that Sally often ate chicken when the others ate red meat. Leanne had also taken to buying low fat milk and yoghurt instead of full fat dairy products. The parents were asked to consult their instincts about the kind and quantity of food that Sally would need to eat to gain a healthy weight. They both felt that she should be eating high fat dairy products and red meat, and should also be eating the same size servings as the rest of the family.

At this point in the interview Sally had finished her sandwich and juice but stated that she did not want any

fruit. Winston then proceeded to lean across Michael's seat to ask Sally to try some noodles. The therapist asked Michael to move so that Winston and Leanne were sitting on either side of Sally. Winston was persistent in his requests, which was praised by the therapist. Sally became angry after the fourth request, telling him curtly to change seats again. The therapist then asked Michael to guess what effect his father's attempts were having on Sally. He said she was angry because she would feel her father was hassling

“The parents were asked to attempt to get Sally to eat one more mouthful than she wanted to. Sally was also asked to resist their attempts...”

her. He also felt that she did not like being hassled in front of the therapist, whom she did not know very well. Sally agreed with these guesses and her anger seemed to settle. Winston and Leanne were then asked to continue standing up to the illness. This process continued for twenty more minutes. On one occasion Leanne started to negotiate with Sally about the caloric content of the noodles. The therapist then asked Leanne if she had done this before and how effective it had been. She was encouraged to continue the monotonous requests with her husband. At 1.25 p.m. Sally asked the therapist if she had to eat a lot or only one taste. The therapist referred this question to the parents who indicated that she only had to have one mouthful. Sally then proceeded to eat this just in time for the end of the session. The family were congratulated on their success, but agreed that this process might be a lot harder at home. They agreed to eat their breakfast together, and Winston said that he would arrange with his work to be home for dinner two week nights per week.

Continued Focus on the Refeeding Process

The remainder of Phase I took nine weekly sessions. In this time Sally's weight rose to 40.5kg, with no weight gain in the first two weeks and a decrease of 500g on week five. In the first two weeks, the parents had been successful in introducing high fat dairy products, but Sally had compensated by 30-minute daily periods of exercising in her room. The parents then agreed to stand up to this behaviour and developed a joint strategy of checking on her every five minutes when she was in her room. The therapist was careful to reinforce their success with dairy products, and their team approach to exercising. Michael had some difficulty forming an alliance with Sally in this first two-week period and was tempted on numerous occasions to join the parenting team in their refeeding task. Sally said this made her feel like everyone in the family was against her.

Winston and Leanne decided to help Michael by reminding him when he attempted to join them.

From this point on, Winston and Leanne progressed well with the refeeding task. Michael also improved in his attempts to form an alliance with Sally. They had little success with getting Sally to eat red meat, but increased her intake of chicken and pork instead. They were gradually able to increase the amount of food she ate at each meal. Their main strategy was to insist monotonously, but they also developed more creative approaches. One strategy was to remind Sally how much she had disliked her stay in hospital. Another was to name anorexia 'Annie' and remind her jokingly when it was bossing her around. One two occasions Leanne became angry with Sally during refeeding when Winston was not home at dinnertime. Winston decided to call Leanne on the nights when he could not be home, to support her in the refeeding process.

The family expressed some disappointment at week five when Sally lost 500g. The father requested that the therapist focus on telling his wife that she was responsible and stated that Leanne and Sally were both as stubborn as each other. He wondered if family relationships could be a focus of the therapy rather than simply concentrating on food. The therapist was very clear in pointing out the dangers of concentrating on issues that were not directly related to eating, given that Sally was still at serious medical risk. Further exploration of the events of this week revealed that Winston had worked very long hours due to the absence of his manager and that he had been quite critical of his wife upon his return home. This was again reframed as a product of his own concern for Sally, and as an attempt by the illness to split them up as a parenting team. The therapist revisited the collapsing time strategy from the first session, asking the parents about what might happen to Sally if the anorexia continued to be successful in this way. Careful plans were put in place to take back this ground from the illness. The father agreed to come home for dinner for the next week and both parents would follow strategies that had already worked in the past five weeks.

Phase II: Negotiating for a New Relationship

At week ten, the therapist and the parents decided to move to Phase II of treatment. The parents felt that Sally was well on her way to recovery, and expressed some relief that they had been able to take charge of the illness. They both felt comfortable with gradually handing some responsibility back to Sally. A two-week experiment was set up for Sally to eat breakfast for two days per week without her mother or father present. Her parents also allowed her to go on a day trip with a group of girl friends and planned carefully which foods she would buy and eat. Within two weeks Sally had gained another 1kg and reported menstrual spotting. The parents also reported that they no longer needed to remind her to eat. The family was now eligible for the commencement of Phase III.

Phase III: Adolescent Issues and Termination

The main adolescent concerns raised by Sally and her family involved conflict regarding Sally's choice of social activities. Her parents were keen for her to become involved in a Chinese church and to join the youth group with other Chinese adolescents. Sally was more interested in socialising with adolescents from school from a variety of cultural backgrounds. The therapist was initially concerned that marital tensions might also be raised, due to Winston's tendency to blame Leanne for the anorexia, but this was not the case. The therapist assumed that some degree of harmony between the couple had been achieved indirectly by the facilitation of a stronger parenting alliance. The parents and Sally were then asked to try and solve in the session the problem of Sally's friends. They were encouraged to see this tension as a normal part of the life cycle for families from different cultural backgrounds and to find a win/win solution. Sally agreed to attend the church with her parents but not the youth group. The parents agreed to allow her to go out on the weekend with friends from school so long as they had met them beforehand. No further questions were raised.

The family was seen on two more occasions over a two-month period. The adolescent issue regarding Sally's friends was resolved without the need for more intensive family therapy and Sally reached a weight of 41.9kg. Treatment was closed by asking the family to review their progress over the 21 weeks of treatment. The therapist expressed his confidence that they would succeed in the future if any problems arose and each family member was given an opportunity to say goodbye.

Empirical Support

Morgan and Russell (1975) conducted a twenty-year retrospective study of anorexic patients at the Maudsley Hospital and found that while hospitalisation was effective for short-term weight restoration, it did not lead to long-term recovery. This provided the impetus for the introduction of family therapy, corresponding in time with the publication of Minuchin and Selvini Palazzoli's seminal works (Minuchin et al., 1975, Selvini Palazzoli, 1974). By 1985, the Maudsley model had been developed and was subjected to empirical investigation (Russell et al., 1987). Minuchin et al. (1978) had conducted research that showed that 80% of outpatients with anorexia achieved positive outcomes with the structural model, but the Maudsley study was the first randomised controlled trial. Eighty patients were seen in this study upon discharge from hospital and randomly allocated to family or individual therapy for one year. Individual therapy consisted of a combination of cognitive, psychodynamic and strategic therapies. Serious weight loss in the individual therapy involved a focus on risks, including readmission to hospital. A focus on interpersonal relationships and the effect of anorexia on those relationships was also included. The findings from this study were described earlier in the paper,

with family therapy yielding significantly better results for patients under nineteen whose illness had a duration of less than three years. A follow-up study (Eisler et al., 1997) found that recovery had persisted for 90% of the family therapy patients. Fifty per cent of the patients who had undergone individual therapy still had significant symptoms of anorexia. A further preliminary study has been conducted since the manualisation of the Maudsley mode (Lock & le Grange, 2001) with a sample size of 43 families. Findings indicate that the manualised version yields comparable results to the Russell et al. (1987) trial.

While these findings have all been conducted at the Maudsley hospital, they are supported by one further randomised controlled trial conducted in the US (Robin, Seigal, Moye, Koepke, Moye & Tice, 1995). This study is the only other controlled trial ever conducted, and compares the use of Minuchin style family therapy to psychodynamic psychotherapy for adolescents. Family therapy was again shown to be significantly more effective, and resulted in more substantial improvements in family relationships. The combination of all of these studies led Mitchell and Carr (2000), in their detailed summary of empirical evidence for the treatment of anorexia, to describe family therapy as the treatment of choice for anorexia nervosa in childhood and adolescence. It is important to emphasise, however, that this position is not applicable to patients with an illness of greater than three years duration. Treatment practices for this group of children and adolescents still require extensive research. Research with adults shows that personality disorders are prevalent for patients with eating disorders (Westen & Harnden-Fischer, 2001). It is possible that adolescents with a longer duration of anorexia have already developed personality disorders, which would require the addition of more analytically focused therapy (Dare, 1997). It is also possible, however, that all forms of therapy might be thwarted by starvation-mediated neurological damage (Katzman, Christensen, Young & Zipursky, 2001).

Conclusion

The evolution of the Maudsley model is relatively rare in family therapy in a variety of ways. Firstly, its development has been closely linked to empirical research, from the first study of the efficacy of medical in-patient treatment (Morgan and Russell, 1975), to the more recent study regarding the effects of expressed emotion (le Grange et al., 1991). Empirical support has also been exemplary in that it has consisted mainly of double-blind controlled trials and has included a five-year follow up study (Eisler et al., 1997). In this sense, it demonstrates an interaction between the 'listening heart and the chi square' (Dare et al., 1995) which is still relatively rare in the history of family therapy. The Maudsley model is also novel in that it happily integrates modern and postmodern influences. Minuchin's structural approach is essentially rescued from its first order problems by a firm belief in the family as a resource rather

than as the problem, by the consistent use of the technique of externalisation, and by the care with which the clinician asks questions (including circular questions) rather than presenting herself as an expert.

This kind of balance between science and art, and between structuralism and constructivism, seems to make the most sense when tackling an illness with such serious medical consequences. The Maudsley model has rejected an 'either/or' position and instead drawn on several of the strengths the history of family therapy has offered. This seems to follow Richard Rorty's view (1999) that pragmatism, rather than claims of 'truth', should guide our beliefs. Empirical support suggests that while everybody in family therapy may have had different opinions, in combination they have all been right.

References

- Dare, C., 1981. Family Therapy for Families Containing an Anorexic Youngster. In *Understanding Anorexia Nervosa and Bulimia. Report of the Fourth Ross Conference in Medical Research*, Columbus, OH, Ross Laboratories.
- Dare, C., 1985. The Family Therapy of Anorexia Nervosa, *Journal of Psychiatric Research*, 19: 435–453.
- Dare, C., 1997. Chronic Eating Disorders in Therapy: Clinical Stories Using Family Systems and Psychoanalytic Approaches, *Journal of Family Therapy*, 19, 3: 319–353.
- Dare C., Eisler, I., Colahan, M., Crowther, C., Senior, R. & 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: 31–57.
- Eisler, I., Dare, C., Russell, G., Szmukler, G., le Grange, D. & Dodge, E., 1997. A Five-Year Follow up of a Controlled Trial of Family Therapy in Severe Eating Disorders, *Archives of General Psychiatry*, 54: 1025–1030.
- Fischer, M., Golden, N., Katzman, D., Kreipe, R., Rees, J., Schebendach, J., Sigman, G., Ammerman, S. & Huberman, H., 1995. Eating Disorders in Adolescence: A Background Paper, *Journal of Adolescent Health*, 16: 420–437.
- Haley, J., 1973. *Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson*, NY, Norton.
- Hoffman, L., 1985. Beyond Power and Control: Towards a Second-Order Family Systems Therapy, *Family Systems Medicine*, 3: 381–396.
- James, K. & MacKinnon, L., 1986, Theory and Practice of Structural Therapy: Illustration and Critique, *ANZJFT*, 7: 4, 223–233.
- Katzman, D. K., Christensen, B., Young, A. K. & Zipursky, R. B., 2001. Starving the Brain: Structural Abnormalities and Cognitive Impairments in Adolescents with Anorexia Nervosa, *Seminars in Clinical Neuropsychiatry*, 6, 2: 146–156.
- Le Grange, D., Eisler, I., Dare, C. & Russell, G., 1991. Evaluation of Family Treatment in Adolescent Anorexia Nervosa; A Pilot Study, *International Journal of Eating Disorders*, 12, 4: 347–357.
- Lock, J., le Grange, D., Agras, W., Dare, C., 2001. *Treatment Manual for Anorexia Nervosa: A Family-Based Approach*, London, Guilford.
- MacKinnon, L., 1988. Openings: Using Questions Therapeutically, *Dulwich Centre Newsletter*, Winter, 15–18.

- Meads, C., Gold, L. & Burls, A., 2001. How Effective is Outpatient Care Compared to Inpatient Care for the Treatment of Anorexia Nervosa? A Systematic Review, *European Eating Disorders Review*, 9: 229–241.
- Minuchin, S., Baker, L., Rosman, B., Liebman, R., Milman, L. & Todd, T., 1975. A Conceptual Model of Psychosomatic Illness in Children, *Archives of General Psychiatry*, 32, 1031–1038.
- Minuchin, S., Rosman, B. & Baker, L., 1978. *Psychosomatic Families: Anorexia Nervosa in Context*, Cambridge, MA, Harvard University Press.
- Mitchell, K. & Carr, A., 2000. Anorexia and Bulimia. In A. Carr (Ed.), *What Works with Children and Adolescents: A Critical Review of Psychological Interventions with Children, Adolescents, and their Families*, London, Routledge.
- Morgan, H. & Russell, G., 1975. Value of Family Background and Clinical Features as Predictors of Long-Term Outcome in Anorexia Nervosa: A Four Year Follow-Up Study of 41 Patients, *Psychological Medicine*, 5: 355–371.
- Robin, A., Seigal, P., Moye, A., Koepke, T., Moye, A. & Tice, S., 1995. Family Therapy vs. Individual Therapy for Adolescent Females with Anorexia Nervosa, *Journal of Developmental and Behavioural Paediatrics*, 15, 2: 111–116.
- Rorty, R., 1999. *Philosophy and Social Hope*, London, Penguin.
- 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.
- Selvini Palazzoli, M., 1974. *Self-Starvation: From the Intrapsychic to Transpersonal Approach*, London, Chaucer.
- Selvini Palazzoli, M., 1986. Towards a General Model of Psychotic Family Games, *Journal of Marital and Family Therapy*, 12: 339–349.
- Steinhausen, H., Rauss-Mason, C. & Seidel, R., 1991. Follow Up Studies of Anorexia Nervosa: A Review of Four Decades of Outcome Research, *Psychological Medicine*, 21: 447–454.
- Steinhausen, H., Rauss-Mason, C. & Seidel, R., 1993. Short Term and Intermediate Term Outcome in Adolescent Eating Disorders, *Acta Psychiatrica Scandinavia*, 88: 169–179.
- Szmukler, G., Eisler, I., Russell, G. & Dare, C., 1985. Anorexia Nervosa: Parental Expressed Emotion and Dropping Out of Treatment, *British Journal of Psychiatry*, 147: 265–271.
- Vaughn, C. & Leff, J., 1976. The Influence of Family and Social Factors on the Course of Psychiatric Illness: A Comparison of Schizophrenia and Depressed Neurotic Patients, *British Journal of Psychiatry*, 129: 125–137.
- Westen, D. & Harnden-Fischer, J., 2001. Personality Profiles in Eating Disorders: Rethinking the Distinction between Axis I and Axis II, *American Journal of Psychiatry*, 158, 4: 547–562.
- White, M. 1986. Negative Explanation, Restraint and Double Description: A Template for Family Therapy. In *M. White Selected Papers*, Adelaide, Dulwich Centre.
- White, M., 1987. Anorexia Nervosa: A Cybernetic Perspective, *Family Therapy Collections*, 20, 117–129.
- White, M., 1988. The Externalising of the Problem and the Re-Authoring of Lives and Relationships, *Dulwich Centre Newsletter*, Summer: 5–28. 

Editors and their Sheds

‘Veronica had a clearness of vision from PMT’

(Bronwyn Rodden, ‘Eating Clouds’: 93, in *fourW thirteen: A Collection of Poetry and Prose*, ed. Christine Ferrari and David Gilbey, Wagga Wagga, Four W Press, 2002).

For clearness of vision, we recommend, not PMT, but:

Roughan, Penny and Jenkins, Alan, 1990. A Systems-Developmental Approach to Counselling Couples with Sexual Problems. Part I, Theoretical Framework, *ANZJFT*, 11, 3: 129–139.

Roughan, Penny and Jenkins, Alan, 1990. A Systems-Developmental Approach to Counselling Couples with Sexual Problems. Part II Strategies for Intervention, *ANZJFT*, 11, 4: 193–201.

Samuels, Andrew, 1999. Therapy in/and/of/by the World [plenary], *ANZJFT*, 20, 3: 121–127.

Sanders, Catherine, 1989. Lessons My Clients have Taught Me [plenary], *ANZJFT*, 10, 4: 205–209.

Available from the editors @ \$10.90 per issue (\$10.00 + 0.90 GST) and \$16.30 (\$15.00 + \$1.30 GST) for issues that are available only as photocopies). Postage extra.

Australian and New Zealand Journal of Family Therapy

Editors: Hugh and Maureen Crago
4 Jellicoe Street, Blackheath NSW 2785, Australia.
email: mhcrago@mail.bigpond.com