

**EMOTIONALLY FOCUSED FAMILY THERAPY FOR BULIMIA:  
CHANGING ATTACHMENT PATTERNS**

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*This article provides an overview of an emotionally focused family therapy intervention for bulimic adolescents referred to an outpatient hospital clinic. The article attempts to integrate theory, practice, and preliminary research results. Bulimia is viewed from the theoretical perspective of attachment theory as described by Bowlby (1969). The emotionally focused approach to creating more secure attachment in families is described, outcome on a small number of adolescents is noted, and the implications of these theoretical and empirical points are discussed.*

Although there have been numerous systemic formulations of bulimia nervosa (Roberto, 1986; Root, Fallon, & Friedrich, 1986) and systemic interventions have become established as an important part of treatment of eating disorders (Gurman, Kniskern, & Pinsof, 1986), the treatment of bulimia with outpatient family therapy is still in an early phase of development. Influential authors have popularized the use of family interventions for eating disorders in general (Minuchin, Roseman, & Baker, 1978; Selvini-Palazzoli, 1978), and there are some empirical data on the effectiveness of family therapy for anorexia nervosa (Dare, Eisler, Russell, & Szmukler, 1990). Although a few descriptions of family therapy for

bulimia can be found in the literature (e.g., Schwartz, Barrett, & Saba, 1985), empirical data on treatment outcome are exceedingly rare. One of the few controlled studies in existence (Russell, Szmukler, Dare, & Eisler, 1987) suggests that family therapy interventions work well for young anorexic patients but may not be particularly effective for older adolescents suffering from bulimia.

The central tenet of family approaches to eating disorders is that eating disorders are caused and/or maintained by dysfunctional family relationships or structure, including inappropriate boundaries, roles, and alliances (Minuchin et al., 1978). A general dedication to achievement and competitiveness has been noted in the families of bulimics (Schwartz et al., 1985). The problematic interaction patterns that have been considered most significant in the families of bulimics, however, are enmeshment and overprotectiveness, rigidity, lack of conflict resolution, and involvement of the patient in parental conflict (Minuchin et al., 1978). The evidence that these patterns typify the families of bulimics and prime bulimic symptoms is, in fact, sparse and inconsistent.

Humphrey (1989) analyzed the interactions of families with eating disorders using the SASB (Structural Analysis of Social Behavior) scale and found that family interactions of bulimic patients were characterized by more hostile engagement and less nurturance than were the family interactions of controls or anorexics, but it is unclear how these qualities relate to enmeshment as described by Minuchin. Kog, Vandereycken, and Vertommen (1989) observed families with eating disorders and found that very few families fit the classic description of enmeshment. Other self-report studies also found that compared to controls, bulimic women do not see themselves as closer to, or more cohesive with, their parents (Dolan, Lieberman, Evans, & Lacey, 1990; Shis-slak, McKeon, & Crago, 1990). In fact they see

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their parents as disengaged (Wonderlich, Klein, & Council, 1996). Kagan and Squires (1985) also found that compulsive eating was associated with a lack of cohesion rather than enmeshment. Similarly, Harding and Lachenmeyer (1986) found no differences between eating disorder subjects and controls on the enmeshment, overprotectiveness, and rigidity subscales of a family interaction scale specifically designed to measure the concepts of Minuchin's theory. The families of anorexics and controls report more cohesion than the families of bulimics (Johnson & Flach, 1985; Kog, Ver-tommen, & De Groote, 1985; Stern et al., 1989), and in general it seems that, in bulimics' families, disengagement and distance are the issues rather than enmeshment. Compared to anorexics, the families of bulimics seem to be unsupportive, detached, and hostile (Armstrong & Roth, 1989).

Other concepts in the original systemic formulation of the dynamics of families with eating disorders, such as rigidity, have also failed to differentiate these families from normals (Shis-slak et al., 1990). Rather than conflict avoidance, studies have found higher levels of conflict in these families (Humphrey, 1989; Kog et al., 1985; Ordman & Kirschenbaum, 1986), and the concept of triangulation is as yet unverified. In general the concepts discussed above tend to be vague, not well operationalized, and not clearly pathogenic. The key concept of enmeshment in particular has recently been criticized as lacking conceptual clarity (Green & Werner, 1996) and confusing coercion with closeness and caregiving.

The equation of intimacy with fusion and the loss of autonomy has been identified by feminist writers and attachment theorists as part of the pathologization of dependency that has characterized the mental health field (Bowlby, 1988). It is accepted clinical wisdom, however, that, particularly for bulimics, whose symptoms appear later than is typical for anorexics, issues of affiliation and control seem to play a part in symptom maintenance. Another perspective that addresses these same issues and parallels the systemic concepts outlined above, while offering a possible refinement in the sense of a more parsimonious and operationalized conceptual framework, is attachment theory (Marvin & Stewart, 1990).

The attachment perspective views a secure emotional connection to significant others as an adaptive, wired-in survival mechanism that fosters optimal development and mastery of the envi-

ronment (Bowlby, 1969). A secure connection to an accessible and responsive attachment figure fosters a sense of felt security, which then allows for flexibility, open communication, and autonomy. This perspective views autonomy and secure connectedness with significant others as two sides of the same coin, rather than as opposing or conflicting elements. It also parallels the literature on adolescent development, which suggests that successful development is optimized by a family's ability to balance needs for individual growth and connectedness while providing nurturance (Baumrind, 1991; MacKay, 1996). This perspective has given rise to a large body of research that examines the relationship between attachment and the creation of resilience (Egeland, Carlson, & Sroufe, 1993; Mikulincer, Florian, & Weller, 1993), the process of normal child and adolescent development (Armsden & Greenberg, 1987), and psychopathology in adolescence and adulthood (Atkinson & Zucker, 1997). The quality of attachment has been related to depressive symptoms and anxiety and to antisocial behavior (Kobak, Sudler, & Gamble, 1991; Lyons-Ruth, 1996). Empirical evidence suggests that the challenge in adolescence is to realign and reorganize the connection with parents in a way that maintains the adolescent's sense of the family as a safe haven and fosters confident exploration of the world, rather than to lessen that bond (Grotevant & Cooper, 1984; Ryan & Lynch, 1989).

The attachment perspective allows for a greater focus on disengagement and insecurity as a source of distress and symptom development, rather than on the concepts outlined previously, such as enmeshment. It stresses that separation without connectedness is experienced as loss and isolation. It therefore has the potential to help refine the clinician's map for family interventions and to promote therapy as a place where parents and adolescents can reorganize their bond to allow for separateness and togetherness, difference and identification, rather than the relinquishing of the bond and the creation of boundaries.

There is also research to support the concept that eating disorder patients exhibit more severe separation and attachment difficulties than do normal adolescents or adults who undergo relationship crises. Bulimics are more likely than anorexics to be impulsive and to engage in activities such as substance abuse, promiscuous sexual activity, and self-mutilation (Polivy, Herman, & Garner, 1988); these activities have been found

to be typical affect regulation strategies for insecurely attached individuals (Brennen & Shaver, 1995). Armstrong and Roth (1989) found that 96% of adolescents with eating disorders evidenced a particular attachment style, namely anxious attachment (in the general population only 24% of normal adolescents display this style), with its concomitant sense of diminished self-worth and self-efficacy. In anxious attachment, which is also called ambivalent or preoccupied, the attachment figure, who is a potential source of emotional comfort and nurturance, is both longed for and obsessively pursued and also pushed away and mistrusted. It is striking that the bulimic repeats exactly this strategy with food, another form of nurturance.

Bulimia has generally been viewed as a reflection of emotional hunger and deprivation in families, and bulimics have been found to be generally less securely attached and less autonomous than controls (Humphrey & Stern, 1988; Ratti, Humphrey, & Lyons, 1996). They tend to come from families characterized by lack of warmth and hostile control, who are unable to support separation and still remain loving and connected. The connection between leaving home and/or the loss of a love relationship and the onset of eating disorders is also well documented (VanDen Broucke & Vandereycken, 1986). The mean age of onset for bulimia is 17 to 19 years of age when most adolescents are facing the task of leaving home for the first time. Adolescents may find attachment figures inaccessible or unresponsive at the precise moment when they particularly need to know that facing the world as an adult does not mean facing the world alone. They may then turn to bingeing as a source of self-soothing, or as a way of escaping a focus on self that is unflattering and evokes a sense of rejection and failure (Heatherton & Baumeister, 1991). A sense of security then comes from controlling needs for food and nurturance, rather than from safe attachment with others. Thinness is also often seen as a way of ensuring the approval and presence of others. The depression that so often accompanies eating disorders can also be viewed in terms of insecure attachment and as part of the process of separation distress.

Several approaches to family therapy explicitly focus on separation distress and attachment insecurity and use attachment theory as a general guide to intervention (Byng-Hall, 1995; Diamond & Siqueland, 1995; Johnson, 1996). The remain-

der of this article will focus on the emotionally focused approach (Johnson, 1996, 1998; Johnson & Lee, in press) to family therapy and how this is applied to the families of bulimic adolescents. We will also present some preliminary data on outcome.

### **Emotionally Focused Family Therapy (EFFT)**

The goals of EFFT are to modify the distressing cycles of interaction that create and maintain attachment insecurity in family members, particularly in the adolescent who is the identified patient (IP), and foster positive cycles of accessibility and responsiveness (Johnson, 1996; Johnson & Lee, in press). These positive cycles then define the family as a safe haven for the adolescent and create a more secure bond. Such a bond fosters optimal development and adaptive coping. It also allows the adolescent to leave his or her family without losing that family. In EFFT emotion is seen as the music of the attachment dance, that is, as organizing key emotional responses that define the quality of the attachment between the IP and other family members. The therapist helps the IP engage and reformulate her emotional experience in a way that creates new points of contact with others and gradually redefines attachments in the family. Since intense emotion evokes implicit self-definitions, this process also impacts the adolescent's sense of self.

The assumptions of EFFT are generally the same as when the emotionally focused approach is applied to couples. EFFT tends to be somewhat shorter (an average of 10 sessions) than the couples intervention and is only now beginning to be researched in terms of treatment effects, whereas the couples intervention has been well validated empirically (Johnson, Hunsley, Greenberg, & Schlinder, in press). The assumptions of EFFT are these:

1. Problems in relationships are maintained by rigid negative interaction patterns that reflect and create absorbing emotional states of fear, grief, and anger. Emotional state and interactional pattern mesh to form compelling family dramas that narrow communication and increase insecurity.
2. Family conflicts that elicit symptomatic behavior are most usefully viewed as attachment dilemmas resulting in separation distress. Attachment needs for security, protection, and contact are healthy and adaptive. It is how

these needs are enacted, constrained, or denied in a context of perceived insecurity that becomes problematic. These needs are naturally most intense at times of transition and crisis when the responsiveness of others is most salient. The more securely attached a person is, the more he or she can turn to attachment figures for comfort and the more independent and confident he or she will be. Insecurely attached adolescents tend either to heighten expressions of anger and distress and aggressively demand reassurance or to disengage and minimize expressions of distress precisely when they are most in need of support. The recognition and validation of attachment needs is a key part of EFFT, addressing what Gilligan calls the female of adolescent's "despair over disconnection" (1987, p. 66).

3. Emotion is key in organizing attachment behaviors and a crucial element in self-regulation and the formation of identity schemas or working models. The accessing and reorganizing of key emotional experiences is the most powerful route to new interactional responses that then redefine an attachment relationship and foster the modification of negative self schemas. Insight, catharsis, and rational negotiation are often less potent and unable to create new nurturing interactions. New emotional experience that is enacted in new interactions with attachment figures is the most powerful way to create intrapsychic and interpersonal change.

### **The Process of Therapy**

The EFFT therapist frames family members' experiences in terms of deprivation, isolation, and loss of secure connectedness. An attachment frame focuses family members on the relationship rather than on individual members' faults or mistakes (Diamond & Siqueland, 1995). In EFFT, the family is seen all together for the first one or two sessions. The therapist encourages each member of the family to describe his or her perception of the problems faced by the member with the eating disorder and how the family has tried to deal with this situation. The therapist also elicits specific descriptions of problematic interactions, incidents, or crises that the family has experienced. A history of how family life has evolved is also elicited. The therapist, in keeping with the assumptions of the emotionally focused model, validates each member's perceptions and focuses

on the strengths of the family. The therapist identifies problematic relationships and family cycles that appear to be associated with the problem and begins to place family members' individual responses in the context of this cycle. For example, in a case that will be described later, the cycle involved a father who pressured his oldest daughter to perform in school and a mother who withdrew into her career. The daughter became silent and withdrawn, secretly binge eating and vomiting.

After the initial sessions that identify the attachment patterns and negative cycles in the family, different family subsystems are invited to the sessions. Typically the parents are invited to talk about their parenting role, the sibling subsystem will also be seen, and the identified patient will be seen alone, with both parents, or with one parent. This approach involves a flexible combination of dyadic, triadic, and family group sessions as well as at least one individual session with the adolescent. Dyadic sessions allow for more emotional engagement and a more intense focus on the quality of an attachment relationship. Individual sessions strengthen the alliance between the adolescent and the therapist and allow the adolescent to disclose events that are difficult to talk about in front of parents. Treatment usually involves 10 to 12 weekly sessions and ends with a session where all family members are present to ensure that specific changes are integrated into the system as a whole. Treatment is markedly different if there is abuse or violence in the family, since the expression of vulnerability or attachment needs may not be respected and may place family members at risk. The treatment of such families is not discussed in this article.

The process of change has been outlined in three stages and nine treatment steps (Johnson, 1996; Johnson & Lee, in press). The first four steps involve assessment (Step 1), the identification and articulation of the negative cycle that undermines secure attachment (Step 2), the accessing and expression of unacknowledged emotions that prime this cycle (Step 3), and reframing the problem in the context of attachment needs and interactional cycles (Step 4). The goal of this first stage, apart from the creation of a strong therapeutic alliance with family members, is the de-escalation of negative interactions and the framing of a shared version of the problem that validates all and blames no one; that is, a version that elicits cohesion and collaboration.

The next three steps of therapy involve significant shifts in the interactional positions of family members. Withdrawn and distant members are able to become engaged and available, and aggressive or critical family members are able to disclose their attachment emotions and needs. This process unfolds in a manner that evokes responsiveness and creates bonding events that redefine the family as a safe haven and a secure base. The first step involves the active exploration of and engagement with disowned or unformulated attachment emotions and needs, the expression of which creates new forms of dialogue with attachment figures (Step 5). For example, a daughter might be able to talk to her father about the sense of despair that arises when she feels that she has disappointed him. In Step 6, the therapist helps the other accept the emotions and needs expressed in Step 5. In Step 7, the therapist structures interactions where the IP directly expresses the needs that arise out of the emotions expressed in Step 5 and helps the other to respond in an empathic manner that fosters secure bonding.

The last two steps of therapy (Steps 8 & 9) consolidate the new interactions choreographed in previous sessions, integrate them into the family system, and foster new problem solving processes. A more flexible and collaborative approach to problems now naturally emerges since discussions are no longer contaminated by compelling attachment fears and losses and concerns about how the family relationships are defined. One of the few process studies of change in family therapy found that safe emotional engagement facilitates successful problem solving (Friedlander, Heatherington, Johnson, & Skowron, 1994).

### *Interventions*

Emotionally focused marital and family therapies combine experiential techniques for exploring and reformulating intrapsychic responses, particularly emotional responses, and structural systemic approaches to changing interactions. The therapist is a process consultant who moves from a focus on intrapsychic processes to a focus on setting interpersonal tasks.

The main interventions associated with exploring intrapsychic experience are (a) focusing on and reflecting experience; (b) validating individual's perspectives and responses; (c) expanding experience by evocative exploration using open questions; and (d) heightening such responses by

the use of imagery and repetition and adding to the formulation of experience by empathic interpretations, often using an attachment perspective. The interventions associated with restructuring interactions are reflecting and describing cycles of interactions and their impact on the family, framing individual responses in the context of such cycles and in the context of attachment needs and longings, and directly shaping interactions. These interventions are illustrated below within the context of a case example.

### *Case Example*

In Jane's case, the family was referred by a family physician who was concerned that Jane was depressed and that her bulimia appeared to be worsening. The EFFT therapist listened to the family story of a bright, well-adjusted child who related well to her older sister and her parents until just over a year before the session. She then joined a new group of friends and seemed to spend her time as her father, Ben, described it, "hanging out at malls, letting her school work slide, either not eating or stuffing herself, and throwing up and retreating to her room at home." The therapist reflected Ben's experience of frustration that his daughter seemed to have changed and focused on his sense of being unable to reach his daughter, with whom he was formerly very close. Jane was sullen and withdrawn, except when she remarked angrily that all her father did was lecture her on working harder in school.

The therapist focused on Jane's connection to family members and heightened her comments on how isolated she felt in the family, particularly how she had lost the closeness with her father. Jane's mother, Mary, admitted that she was "puzzled" by the change in Jane, but felt rebuffed when she reached out to her daughter. Jane's older sister, Cindy, experienced Jane as angry and "impossible" and had decided to avoid her as much as possible. The therapist reflected on each person's experience of the family and of Jane's problematic behavior and also emphasized the general sense of loss in the family. The therapist then presented her view of the pattern that had "captured" the family and asked them to help her correct and revise it. The pattern was that over the last year Jane had progressively withdrawn from her family and comforted herself by binge eating. Ben expressed his concern by giving Jane advice, which she experienced as criticism. Mary felt pushed away by Jane and feeling helpless, had withdrawn. She then focused her energies on Cindy, Jane's sister. Withdrawal and criticism primed each other and had taken over family interactions, making it difficult for family members to stay emotionally engaged and supportive of each other. The family accepted this description of the cycle, and the therapist elaborated on the fact that this cycle had emerged for legitimate reasons and now had a life of its own.

The key moments in therapy then evolved as follows:

- 1) In an individual session with the therapist Jane disclosed that her problems had started when she had been assaulted and nearly raped and had felt unable to tell her parents about this. At the time she was feeling distant from her father, who seemed "always disappointed" in her and her grades in school. Jane had then decided that the assault had been her fault. She should not have been at an older teen's party, and her parents did not know she was there. She had felt "dirty" and "ashamed"

and decided not to tell anyone. The therapist validated her distress and fear of confiding in her parents and helped her name and organize her traumatic experience. Jane also confided that she had been cutting her arms as a way of punishing herself and exiting from her sense of being "caught back there and feeling lost and dirty." Jane agreed that she would like the therapist's help in sharing this with her parents.

2) In a session with Jane and her parents, Jane confided that she had been nearly raped and, in response to her mother's attempt to minimize this event, she dramatically pulled up her sleeves and showed her parents her lacerated arms. The therapist supported the parents in their surprise and shock and helped Jane begin to place her withdrawal and her attempts at self-soothing (binge-eating and cutting her arms) in the context of her trauma and her sense of shame. The therapist used evocative questions to elicit an emotional response from Mary, which crystallized into grief that she had not tried harder to reach her daughter. Mary described how she felt that she had failed as a mother and so had decided to leave most of the parenting to Ben.

The therapist helped Jane articulate her fears of her parents' disapproval and offered an interpretation of how the family had been paralyzed by their shame and fear and had been unable to reach each other. Ben responded by agonizing over his "lectures" and confided his fears of his daughter being "swept away by all the perils of adolescence" and then failing in school, as he himself had done. Ben and Mary were able to express sadness at their distance from their daughter and their concern about her facing her trauma by herself. The therapist encouraged Jane to ask for what she needed from her father. She asked for reassurance and approval that was not contingent on getting top grades. From her mother, she asked for time to be together and for physical comforting. Both parents responded emotionally, offering comfort, support, and protection. The therapist framed the mother's arms and the father's trust in his daughter as a safe haven that could replace the solace of a bag of chips and a razor blade.

3) In a session with her sister the therapist heightened Jane's experience of being cut out of her mother's and her sister's close relationship and her resentment at that. The therapist reflected and validated Jane's sense of anger at being "left out" and fostered the evolution of this emotion into sadness at the loss of connection between the sisters. Cindy shared her experience that Jane was her father's favorite daughter and that she also missed being close to Jane. Both sisters were then able to ask for more contact and sharing from the other.

4) In a final session the family was able to discuss the cycle that had alienated them and how they were now able to escape from it. They were also able to describe positive cycles of confiding. For example, when images of the assault had come up for Jane she was able to seek comfort from her mother instead of eating or cutting. Her mother shared how special this made her feel and how it encouraged her to reach out more to her daughter. They were then able as a group to discuss ways to help Jane eat more consistently and to agree on expectations around school achievement. Six months later Jane reported that she no longer binged or vomited or cut herself. She also had reinitiated contact with an old group of friends and spent less time in the mall. Her family physician reported that she was also no longer depressed.

This case is representative of the cases treated using emotionally focused interventions, many of

which have involved trauma. Eating disorders are associated with sexual trauma (Polusny & Follette, 1995) and the avoidance of painful emotions and memories in general (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). The parents in this family were, however, more than usually responsive to their daughter once they saw her distress and the patterns that had taken over family interactions. The process of therapy was thus expedited. The EFFT therapist will often support the parents more than was necessary in this case example by validating their desire to be "good" parents and by clarifying the anxieties and stressors that prime their part of the negative interaction cycle.

### Preliminary Outcome Data

A small pilot study has been completed on the use of EFFT with adolescents who exhibited eating disorders. The subjects were 13 young women (the mean age was 17) who met DSM-III-R criteria for Bulimia Nervosa and who were recruited from a waiting list at a hospital outpatient eating disorder clinic. The study was designed to include more subjects but was curtailed by changes in programming. Subjects were randomly assigned to EFFT or a cognitive-behavioral educational group (CBT). Twenty-three women declined to participate in the study; of these 40% stated that they did not want their family members involved in their treatment, and 32% stated that their families were unaware of their eating disorder. The group therapy condition was used as an established reference treatment that had already been tested on a larger sample ( $N = 69$ ) and found to have positive results (Blouin et al., 1994). The small number in this group ( $n = 4$ ) was the result of 4 clients dropping out of the group before the beginning of treatment. One family also dropped out of EFFT after session one ( $n = 9$ ).

The measures used were as follows: 1) the computerized version of the National Institute of Mental Health Diagnostic Interview Schedule (C-DIS; Blouin, Perez, & Blouin, 1988) confirmed the diagnosis of bulimia; 2) the Diagnostic Survey for Eating Disorders (DSES; Johnson, 1985); 3) the Eating Disorder Inventory (EDI; Garner, Olmsted, & Polivy, 1983); 4) the Bulimic Symptom Checklist (BSCL; Blouin et al., 1988); 5) the Hopkin's Symptom Checklist-Revised (SCL-90-R; Derogatis, 1992); 6) the Beck Depression Inventory (BDI; Beck, Steer, & Garbin,

1988); 7) the Attachment Questionnaire (Bartholomew & Horowitz, 1991). Clients received either a 10-week standardized group therapy program for bulimia or 10 sessions of family therapy following the EFFT format (Johnson, 1996). Group therapists were supervised by the third author, family therapists by the first author.

## Results

The average weight of the clients in the study was 137 pounds (height 5'5"). The average binge frequency was 5.2 times per week and average vomiting was 7.3 times per week. A series of MANOVAS found that both treatments decreased bulimic symptoms as demonstrated by a decrease on the EDI scores ( $F(1,11) = 6.65, p < .05$ ) and BSC scores ( $F(1,11) = 4.79, p < .05$ ). A significant decrease was also found on general psychiatric symptomatology following treatment with CBT and EFFT as demonstrated by decreased severity of symptoms on the SCL-90-R and the BDI ( $F(1,11) = 6.27, p < .05$ ). No differential treatment effects were found. Such effects are hard to find in small  $n$  studies.

Further analyses were conducted on the EFFT group data to determine the extent to which EFFT was effective in treating bulimia. EFFT reduced bulimic symptomatology to an extent comparable to group CBT (Blouin et al., 1994). In particular, binge frequency was reduced by 52% with total remission observed in 44.4% of the clients, and vomiting was reduced by 65% with complete remission of symptoms in 66.6% of patients. Using paired  $t$  tests (pre & post), a significant reduction was noted on the BSCL self-rating scores of bingeing severity ( $t = 4.3, df = 8, p < .01$ ) and vomiting severity ( $t = 3.8, df = 8, p < .01$ ). On the EDI, significant reductions in symptomatology were noted on the subscales of bulimia ( $t = 2.4, df = 8, p < .05$ ), drive for thinness ( $t = 4.0, df = 8, p < .01$ ), and ineffectiveness ( $t = 4.7, df = 8, p < .01$ ). General psychiatric symptomatology significantly decreased following EFFT as noted by decreased severity of symptoms on the BDI ( $t = 2.8, df = 8, p < .05$ ) and on the SCL-90-R subtests of obsessive compulsivity ( $t = 2.4, df = 8, p < .05$ ), interpersonal sensitivity ( $t = 3.8, df = 8, p < .01$ ), depression ( $t = 2.9, df = 8, p < .05$ ), hostility ( $t = 2.5, df = 8, p < .05$ ) and psychoticism ( $t = 3.0, df = 8, p < .05$ ).

Effect sizes for binge frequency on the BSCL and the bulimia subscale on the EDI were .87 and

1.1 respectively. These are very respectable effect sizes for psychotherapy outcome.

## Summary

Given the small  $n$ , one must be cautious about the conclusions that can be drawn from this study. The results are encouraging, however, given that the EFFT protocol is still in the process of being refined. EFFT was as effective as an established group treatment and was associated with better rates for binge and vomiting remission than those reported by Garner et al. (1993) for individual treatment for bulimia. These authors report a 36% remission of vomiting rate after 18 sessions of cognitive behavioral individual therapy. The number of EFFT sessions given was also limited. Other family therapists report considerably longer treatments (33 sessions in Schwartz et al., 1985). Since this was a preliminary study no follow-up was conducted. It is unclear then how lasting treatment effects were. However, in the couples version of Emotionally Focused Therapy treatment, effects tend to remain stable or increase over time (Johnson, Hunsley, Greenberg, & Schlinder, in press). From an attachment perspective this makes sense, since positive interaction cycles have time to consolidate, and inner working models have time to become revised and integrated. It would appear then that a brief family therapy approach that focuses on the creation of secure attachment, in the manner described above, is a promising treatment for bulimia. This is particularly significant in light of the paucity of psychotherapy outcome for bulimics. The authors of a review of 21 studies of individual therapy for bulimia (Mitchell, Hoberman, Peterson, Mussell, & Pyle, 1996) note that most studies have focused on adults and that "there is no scientific information available about the treatment of bulimia in adolescents" (p. 221).

There are two other points that are worth noting. The first concerns attachment style. These styles constitute stable individual differences in attachment behaviors and schemas or working models. Securely attached adolescents tend to have more trusting close relationships, to be more confident and more resilient to stress (Kobak & Sceery, 1988). All but 1 of the 13 subjects of this study rated themselves as insecurely attached on the attachment measure. This finding of general insecurity parallels the Armstrong and Roth study (1989). However, since the time of that study the classification of insecure attachment styles has

been refined, and a Fearful Avoidant style has been delineated (Bartholomew & Horowitz, 1991) and added to the previous insecure categories of Anxious Preoccupied attachment and Avoidant Dismissing attachment. In the present study, 64% of the clients rated themselves as Fearful Avoidant (two endorsed dismissing and two anxious attachment), endorsing the wish to be close but believing that they will be hurt if they allow themselves to depend on others. In the former study most adolescents rated themselves as Anxious Preoccupied, endorsing that they wanted complete intimacy but felt unvalued by others. Both Fearful Avoidant and Anxious Preoccupied styles are characterized by significantly lower levels of self-esteem than other styles (Bartholomew & Horowitz, 1991; Collins & Read, 1990). Adolescents displaying these styles are also likely to have difficulty sending clear attachment signals to caregivers when they are distressed. They are also likely to have difficulty in the tasks involved in the transitions facing late adolescents. They have specific difficulties engaging in the negotiation and problem solving around attachment issues that allow working models of self and other to be revised and updated. Such revision fosters new partnerships with parents, that are characterized by more mutuality (Kobak & Cole, 1991; Kobak & Sceery, 1988). The results in this study suggest that helping bulimic adolescents stand back from and articulate their attachment needs and formulate a more positive sense of self in the context of their most important relationships may be a powerful factor in positive change.

The second point is that the authors were surprised during recruitment to find that so many bulimics kept their symptoms a secret from their families, particularly their fathers, and did not want their families to be involved in treatment. Although young bulimic women tend to see both parents as hostilely disengaged, there is some evidence that the paternal relationship may be particularly important in determining positive self-representations in these women (Wonderlich et al., 1996). This suggests that individual and family therapy should take particular note of how the IP is defined in the relationship with her father. Shame and secrecy has also been identified as a general characteristic of bulimic families (Johnson & Pure, 1986). The fact that bulimics were very consciously selective about treatment modality emphasizes that no one treatment is likely to

address this disorder effectively. The most relevant question is not, which treatment is generally superior, but when and for whom is a particular treatment modality most appropriate? Bulimia is also a multidimensional and multi-determined problem (Vanderlinden, Norre, & Vandereycken, 1992), and different treatments may be necessary to address different aspects of the disorder. It has been suggested that behavioral self-help might be the first line of treatment (Cooper, Coker, & Fleming, 1996), followed by individual, group or, when appropriate, family therapy. If adolescents view their families as conflicted and controlling, family therapy may be a particularly crucial part of the treatment package, since these adolescents do not seem to respond as well to group psychoeducational approaches (Blouin et al., 1994).

Although, as is discussed in the introduction to this article, the characteristics of bulimics' families may not always fit traditional family therapy theories (Freidrich, 1995), the limited data presented here suggests that for some adolescent bulimics who are willing to involve their families in treatment, family interventions based on an attachment perspective may be a valid and useful approach. This approach may also impact many different levels of symptomatology. It may influence, for example, the adolescent's ability to turn to family members for support, the ability of those members to respond, and the adolescent's depression and sense of self. Antonucci (1994) suggests that secure attachment is essentially a combination of trust and empowerment: trust in one's own ability to influence others to respond, trust in others that they will respond, and a sense of power that one can shape one's world in a positive way. This world then becomes a more benevolent place that fosters not just recovery from symptomatology such as bulimia, but also optimal development and resilience to stress.

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