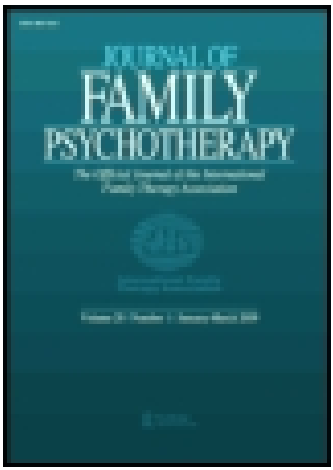

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Richard C. Schwartz PhD [a] & Pam Grace MA [b]

[a] Training and Research , Institute for Juvenile Research , 907 S. Wolcott, Chicago, IL, 60612, USA

[b] Department of Psychology , University of Illinois , Chicago, USA

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The Systemic Treatment of Bulimia

Richard C. Schwartz
Pam Grace

The compulsive bingeing and purging of food, a syndrome that has come to be known as bulimia, has received increasing interest from clinicians and researchers since the relatively recent discovery earlier in this decade of its remarkable prevalence, primarily among women. Because this syndrome is clearly impacted by several different levels of system, e.g., the socio-cultural level, the family level, and the individual intrapsychic level, it can and has been understood and treated very differently depending on which level theorists or clinicians have focused.

For the most part, models for treating bulimia have emphasized one of these levels while devoting far less attention to the other levels, so treatment approaches have been relatively narrow, and limited. This is because theorists have lacked a model that allows one to shift fluidly across levels, using the same principles at each level. This paper presents a model that allows theorists and clinicians to shift from one of these levels to another, as needed, because it views all these levels of system as operating according to similar principles and as highly interconnected.

Some models emphasize the impact of the socio-cultural level, e.g., the pressure on women to be thin, the subordinate status of women, the cultural tendency to look to food for comfort, etc., and work at helping bulimics reexamine their values and behavior in light of these issues (e.g., Boskind-White and White, 1983). Ther-

Richard C. Schwartz, PhD, is Coordinator of Training and Research, Institute for Juvenile Research, 907 S. Wolcott, Chicago, IL 60612.

Pam Grace, MA, is a doctoral candidate, Department of Psychology, University of Illinois, Chicago.

apy derived from these models usually brings clients together into groups to discuss these issues and support each other in trying to change.

Other theorist/clinicians, relying on their clinical impressions and interviews with families, have focused on the interactional patterns of the families of bulimics that are thought to maintain the syndrome. Schwartz, Barrett and Saba (1984) reported that many bulimic families resemble the "psychosomatic families" described by Minuchin, Rosman and Baker (1978), in that they often demonstrated the characteristics of enmeshment, over-protectiveness, rigidity and lack of conflict resolution. In addition, they found these families to be highly isolated, conscious of appearances, and attributed special meaning to food and eating. Root, Fallon, and Friedrich, (1986) categorized bulimic families as either perfectionistic, overprotective, or chaotic, depending on such variables as how the family handled conflict and child rearing. Both of these groups of theorists advocated that the treatment of the bulimic include significant others whose active involvement they believed is crucial to positive outcome.

The most common approach to treating bulimics, however, has focused on some aspect of the individual client's struggle with herself. Most of the work in this area has come from the cognitive-behavioral school which attempts to change both the behaviors and irrational cognitions that surround the binge/purge episode, whether in group or individual therapy (Fairburn, 1984).

As is apparent in the review above, the first author was part of this montage of disconnected approaches by emphasizing the importance of family factors over the other two levels. This changed, however, when, out of his frustration with the limitations of working exclusively with the bulimic's external context, he began to explore with some clients their internal life and how it also was maintaining of this syndrome (Schwartz, 1987a). From those explorations he developed a model that extends systemic thinking into the realm of internal process. With this model, called the Internal Family Systems model, it is possible to see the similarities between the interactions within an individual's "external" family and their "internal" family. It is also possible to intervene at either level using the same systemic paradigm and techniques, rather than having to

shift from a systemic at the family level, to, for example, a psychodynamic or cognitive/behavioral paradigm at the internal level.

In addition, the same paradigm has proven useful for appreciating the impact of the socio-cultural context on the families and individuals embedded within it (Schwartz, 1988). For example, the degree to which a culture, in evaluating its members, emphasizes the importance of material success and vogue appearance over personal qualities such as the ability to be direct or nurturant, will be the degree to which aspects of families and individuals will demonstrate isomorphic imbalances. Unless we can understand the connections between our society's imbalances and those within the families and clients we treat, we will not be able to help them reexamine which socio-cultural values are best for their family or themselves.

UNDERSTANDING THE BULIMIC SYSTEM

While the entire model cannot be described in this space, we will focus on some aspects of it as they apply to families and individuals that have been highly influenced by and strive to achieve the predominant middle class values of the United States, a group that we call "hyper-Americanized," and that we found constituted about one-third to one-half of the families in our study (Schwartz et al., 1984). We will begin by describing the parallels between such a hyper-Americanized bulimic client's internal life and the values of her family.

The Bulimic's Internal System

If a bulimic client is asked to describe her internal experience that surrounds a binge/purge episode, she is likely to describe experiencing a cacophony of inner "voices" or conflicting thought patterns and emotions for a period preceding the binge, during which time she feels increasing tension. The binge itself often quiets or distracts from this internal distress as she feels as if she has become an unthinking, unfeeling "eating machine." As the awareness of the calories being consumed increasingly sinks in, however, another kind of tension mounts which only the purge can diminish.

If asked to focus on the nature of each of these internal voices, many bulimics can identify and differentiate a variety of what can be considered subpersonalities or "parts" of them, each of which has a different intention, view of the world, and strategy for influencing her. In addition, if asked certain questions, a client usually can describe how she relates to each of these parts of her – i.e., how she likes it and it likes her, how often it is around, how often she listens to it and does what it wants – and how the parts relate to each other. When one part comes to dominate the internal process or becomes suppressed or dominated, then symptoms occur. When suppressed parts are expressed, they appear in extreme form. Similarly, rapid fluctuation of high conflict between parts can also render "symptoms." From this kind of interviewing it is possible to get a picture of this internal group as an interacting system in much the same way one gets a picture of a family by tracking relationships and interaction patterns.

That many aspects of a bulimic client's internal system seem to parallel aspects of her external family is not surprising because we believe that the prominent values and themes of her family will determine which parts of her she likes and listens to and which she does not. For example, a bulimic raised in a hyper-Americanized home, will often overvalue and listen to an "achievement part" that pushes her to compete and do perfect work and a dominating "approval part" that tells her she must look perfect to attract a man because she has little else to offer. In addition, she will reject or try to avoid the angry parts of her or the parts that want intimacy and are sad and lonely, because her family, dominated by themes of proper appearance or competitiveness, also disdains these "weaknesses."

Such a strong, controlled exterior is difficult to constantly maintain, particularly since her angry or sad parts are extreme from lack of attention, and these parts will periodically "take over" much to her embarrassment and guilt. These displays of "unsavory" feelings will also bring disdain or over-reaction from her family which will compound her guilt and determination to push these parts away. The more she tries to eliminate these parts the more they struggle to take over. To avoid having this internal struggle go on indefinitely an "indulgent" part will activate and make her think

only of eating, thereby distracting her from the internal turmoil, and the binge/purge cycle is under way. Thus, the bulimia can serve as a distraction from internal conflict in much the same way as it can distract her family from the conflicts resulting from their overvaluing of achievement and appearances and undervaluing assertiveness and intimacy.

With this model then, a therapist will have the same goals whether working at the individual or the family level with these hyper-Americanized bulimic families. At the individual level the goal is to help her control and be less identified with her extremely critical achievement and approval parts while accepting and acting on the nonextreme desires of neglected parts like intimacy and anger. In so doing she increasingly will be able to control and change the role of the indulgent part that triggers the bingeing because its distracting or nurturing role will be less necessary.

At the family level, the goal is similarly to help all members of the family become less obsessed with achievement and appearances so that they can face and deal assertively with the issues that divide them. This allows family members to define their relationships directly rather than indirectly negotiating relationships through who is eating what and how much.

The Hyper-Americanized Family

We have found that the hyper-Americanized families that surround some bulimic clients tend to place extreme importance on appearing stylishly attractive and inordinately successful at all times, and at any cost. These values are reflected in a constant pressure to dress fashionably, to get good grades, to make or marry into a lot of money, and to look "healthy and attractive" (which means look thin). The self absorption and scrutiny as well as the competitiveness that accompanies these values contributes to a family attitude that people should be able to control themselves and should be strong, because the world will take advantage of any weakness.

Relatedly, these families believe that they must at least appear to be perfect, and perfect families do not have conflicts, addictions, or depressions. As in the internal life of the hyper-Americanized bu-

limic client, this pressure to be strong and perfect cannot always prevent overt conflicts from surfacing or sadness from showing. When one or more members display such a "lack of self control" they do so in an extreme way in part because everyone is so afraid of such episodes and reacts so strongly to them. Such outbreaks are followed by attempts to minimize or deny the episode so as to maintain the perfect image or by harsh sanctions against the family member who is seen as precipitating it. It is difficult to exist in such a family without some kind of distraction or method of self-numbing, and it is common to find heavy use of alcohol or tranquilizers in the parents and drug abuse in siblings, in addition to strange eating practices in all members.

In keeping with being highly Americanized, these families are often extremely male-oriented in the sense that men are viewed as more important and valuable than women and so the best chance for a woman to advance is to attract a successful man. Women in these families learn early that the approval of men in general, and their father in particular, is of primary importance, which often leads to competitive feelings among them for his approval. Often the client protects her father from her mother's angry outbursts and feels that she has a special, yet precarious, relationship to him. In some cases it is the sudden loss of this special closeness, often during the sexually charged adolescent period, and the ensuing sense of emptiness, confusion and disapproval that precipitates the bulimia. Often fathers in these families have been overt in their preference for thin, attractive women so the client's approval part is further activated.

Daughters in these families come to see their female peers as competitors and male peers as potential mates and, consequently, have few real friends. Thus their lives are spent in a lonely search for a man to take care of them. They feel great when they get even slight romantic attention from an attractive man or, relatedly, when they have lost weight as a step toward getting such attention, and terrible if they do not get or if they lose such attention, or gain weight.

In addition, these daughters are given conflicting mandates from their families regarding what their life goals should be. Consistent with the perfect family image and competitive approach, they are pushed to achieve in school in an area that the parents value, and yet

are to be nice, and nonthreatening (nonassertive and nonintellectual), so as to attract "Mr. Right." Thus their achievements are inconsistently praised and attended to which reflects their family's ambivalence regarding female achievement. The parents' inconsistent praise for success and consistent criticism for imperfection becomes a model for the way the client's achievement part treats her.

Finally, for many of the reasons outlined above, these hyper-Americanized family systems are not very fulfilling contexts in which to live. Caught up with their extreme achievement parts, fathers work long hours and are preoccupied when they are home. Mothers are often lonely but feel lucky to be married to such successful men and so are afraid to express this loneliness because they do not want to further burden their husbands, who tend to recoil from their unhappiness.

Mothers in such predicaments are likely to become highly involved in their daughters' lives. Many of the bulimic clients we see find themselves in the role of their mother's confidant, therapist or companion. They are trying to comfort and cheer up their mother more often than vice versa, and are usually unsuccessful because they cannot change her context. Clients often report feeling a mixture of guilt and frustration due to mother's unhappiness, and resentment that she was/is so preoccupied as to not be more of a mother to them. Mothers feel a similar mixture of concern over the client's health and frustration with her irresponsibility and inability to control herself—to better model the perfect child. This mixture of extreme feelings (or parts) in the mother-daughter relationship is usually quite combustible and fights erupt quickly over petty issues like eating, dressing, or cleaning. Such fights are more bitter when the client is also protective of her father or in competition with mother for his approval. When her parents are unhappy with each other, the client's parts are highly activated in a complex and confusing inner cacophony that often precedes a binge.

Why Bulimia?

In light of these values and issues, the client's selection of food as a primary indulgence becomes more understandable. Food is the arch enemy of her achievement and approval parts since, in their

eyes, eating leads to weight gain which ultimately leads to rejection by men. Thus, binge eating is seen by those parts as evidence that she is a gluttonous, weak-willed failure. The other parts, such as angry or rebellious parts, that are in opposition to and generally dominated by the achievement and approval parts, then would encourage her to binge eat in defiance of that dominant diet-obsession.

In addition, because members of these families are often so preoccupied with their own personal dramas and are uncomfortable with expressions of sadness, a pattern develops of parents trying to cheer up distressed children by giving them food rather than by comforting them directly. Thus a child learns to look for comestible instead of personal consolation when hurt. Food will fill one up and will not reject one or expect anything in return. Thus the binge satisfies several parts at once—angry or rebellious parts that do so out of defiance, sad or lonely parts that do so looking for nurturance, and, as mentioned above, protective parts that do so to provide a distraction from the internal turmoil. In addition, thinking of oneself as "a bulimic" can reassure those protective parts that fear failure by ensuring that one will not try anything truly risky, like getting close to someone or leaving one's parents' home, until one is no longer "a bulimic."

At the family level, the client's bulimia reassures the parts of her parents that fear life without her, by showing that she is a long way from growing up and still needs their help. It also can provide a "safe" conflict between family members over how best to handle her problem. Finally, it can provide an excuse for the client's displays of anger, depression or other imperfections.

It is important to note however that, in some cases, the bulimic client's symptoms do not appear to serve any indirectly protective function within her family, such as those mentioned above. In addition, even where there appears to be evidence that the syndrome is embedded in indirectly protective sequences, it is a mistake to assume that family members desire or have a stake in the maintenance of the syndrome. Rather, it should be understood that everyone feels oppressed by her symptoms but, sometimes, the family will use bulimia in a distractive or protective way without being aware that such use maintains or exacerbates the syndrome. In other cases,

the bulimia itself will generate difficult sequences in the family that ultimately result in a need for a distraction.

TREATING THE BULIMIC SYSTEM

We have portrayed bulimia as a syndrome embedded in both internal and external sequences of interaction that activate each other. That is, the way a bulimic client's hyper-Americanized family relates to her will activate certain sequences among her internal parts that will, in turn, make her behave in ways that activate extreme sequences among family members, and so on. For change in such systems to be lasting, both the internal and external systems need to be reorganized to some degree. Fortunately, we have found that changes at either level affect parallel changes at the other level, so it is possible, for example, to focus only on family interactions and simultaneously change the client's internal system, and vice versa.

With this perspective, the job of the therapist, initially, becomes to assess which level of system (internal or external) is most amenable to change and, later, to shift the focus of therapy back and forth from internal to external as indicated by the reaction of the bi-level system. For example, where a client is financially and emotionally dependent upon and living with her hyper-Americanized family, working exclusively with her internal system is likely to result in only temporary improvement at best. This is because (1) the external sequences she is amid every day are likely to be so activating of extreme parts that she will not have room to do much internal work, and (2) if she were to rapidly improve and become more independent her untreated family is likely to react in ways that undermine these changes, because of their mixed feelings regarding her independence.

Thus, unless a bulimic client has plenty of room to change, it is wise initially to focus on helping the family explore and change interaction patterns that activate her internal parts and, in that way, contribute to her bulimia. In this process the therapist can lead the family in a reexamination of their values, their living context, and how those factors contribute to the client's problem. To do this without generating defensiveness the therapist needs to adopt the attitude of a researcher who is trying to collaborate with the family

in coming to a better understanding of their predicament. If the therapist is successful in maintaining such an attitude, it will be possible to create with the family an understanding of therapy as a vehicle for all family members to work together. The shared purpose can be to find ways to help each family member, but particularly the client, control or calm down the internal parts of them that are interfering in their lives.

Therapeutic Questions

We have found the following sets of questions yield useful discussions in this endeavor. As the therapist and family explore the above questions, and continually relate them to the client's bulimia, the patterns that activate the client's parts will emerge and can be addressed, again, in a cooperative effort with the family. It is important the discussion be related, not by giving an interpretation but by sincerely asking the family for any connections that they can make. The therapist may pose each question he or she believes applicable to the family in general or, instead, ask who in the family most embodies the values related to the question.

I. Family's Reaction to Bulimia

Many aspects of a family's system of values are revealed in how they have reacted and are currently reacting to the client's symptoms. Often simply discussing these attempted solutions, and the degree to which they are effective, will generate new reactions that will give the client more room to change.

1. How have different family members reacted to and tried to handle the client's bulimia? Who most often tries, or is most likely to try, to ignore or deny symptoms? Who is most likely to try to coerce, intimidate or scorn the client into stopping? Does any family member protect the client from another member or from the outside world because of the bulimia? What are other approaches that have been attempted by family members and what interaction sequences tend to surround the syndrome now? How do these various approaches or sequences

affect the client's internal parts that are involved with the bulimia?

2. How do family members view the client, particularly as related to the bulimia (e.g., as weak, rebellious, a victim, sick, or selfish)? How do these beliefs affect what internal parts tell the client about her/himself? How do family values affect their views of the client (e.g., feelings toward weakness or lack of self-control or inability to control the client). How do different views of the problem contribute to inconsistent or contradictory approaches to it, and the interaction sequences they generate?
3. How does their focus on or concern about the bulimia affect each family member's life? What would happen if the client did not have this problem (e.g., who might be able to do things or talk about issues or talk to each other in ways that they cannot now)? How does the client's awareness of this role of the syndrome affect the internal parts?
4. What might a family context look like that would support the client's efforts to control or calm down the parts involved in bulimia sequences? What parts or values or family members might interfere with the creation of such a context? How could those members be helped to control those parts of them?

The goal of this series of questions is to help the family see that they all (including the client) have internal parts that, when activated by the syndrome, generate interaction patterns that are related to the maintenance of it. With that new view, they can begin to work together to keep those parts of them all from interfering in their lives.

II. Current Family Context

The lasting success of the family's efforts to change their reaction to the client's symptoms will depend on several other factors that can also be explored with the family and are illustrated in the following questions.

1. How physically and emotionally isolated is the family as a unit and is each member; i.e., how much access does each member have to a supportive network and is that satisfactory? Do they have particular values that tend to increase this isolation (e.g., competitiveness, fear of extrafamilial, self-sacrifice)? How does this isolation from outsiders affect the way they relate to each other and to the client?
2. How accessible are they to each other? Who nurtures whom and how? Who is too busy to be supportive or supported? Do they have values that maintain this intrafamily isolation? How does this intrafamily isolation affect the way they relate to each other and to the client?
3. Are there current stresses on key family members that are contributing to patterns of isolation and conflict (e.g., life stage crises, job stress, dealing with a chronic or acute illness, or a loss of an important relationship)?
4. How happy are key members with their current living situation as it relates to their isolation and to the activation of extreme values like hyper-concern with appearances and achievement, or the over-valuing of males?
5. Who in the family does the client worry about the most? How does the client try to help or protect those people? Is this protection necessary and are there other, more direct, ways to help the family? How do these worries affect the client's internal parts? How do the values and isolation of the family contribute to the degree to which these worries are warranted?

The goal of this series of questions is to orient the family to an awareness of how these issues of isolation, stress and emotional support are related to the degree to which they will be able to successfully reorganize their relationships to the client such that work on the internal system can proceed.

III. Family Values

The following are values or beliefs that we have encountered in these hyper-Americanized families that we believe contribute to the elements of context for bulimia outline above. The therapist can ask the family members about the degree to which they subscribe to the

following values, and how those might contribute to the clients problem.

Women should:

1. be competitively achieving in areas that are attractive to high achieving men, but should not threaten men.
2. look perfectly vogue so as to attract a high achieving man.
3. be able to control themselves. Fat is a sign of indulgence and weakness and unhappiness or anger is a sign of lack of gratitude or appreciation for her position in life.
4. expect to be taken care of by a man materially but not necessarily emotionally.
5. see other women as rivals for men, who should not be trusted.
6. have a perfectly clean house, perfectly behaved kids, successful husband, etc.
7. be careful because men will take sexual advantage of them at any opportunity. They need to be protected from temptation.

Members of their family are:

1. to be thought of and given priority before one thinks of oneself.
2. the only ones to rely or depend on. Outsiders are out to get you.
3. basically very close and nice. One can always find things to complain about but it is better to think positively and not dwell on problems.
4. special, better than most people, and should prove that in their achievements and appearance.

Parts Language

Throughout the discussions generated by the questions outlined above we find it helpful to lead the family in using what could be called "parts language" when describing any extreme feelings or values, e.g., "so a part of you believes that a woman is only as valuable as the man she lands, but other parts do not agree" or "so you have a powerful achievement part that never gives you a break—do you like that?" One of the most useful aspects of the

"parts" frame for understanding bulimia is that family members and the client are more able to admit and commit to work on behaviors that contribute to the problem when those behaviors and thoughts are seen as only small parts of them than when they are seen as aspects of their core personality. Thus the parts language helps create an atmosphere of nondefensive exploration that is an unusual and welcome experience for these families.

In addition, the therapist is lifted out of the position of having to try to control the client's bulimia directly or coerce the family into changing the way they treat her. Instead, all members of the therapist/family system are united in collaboration to find a way to keep their extreme parts from running and ruining their lives. During this process the therapist may begin to work individually with the client on changing her relationships with parts of her that are involved in the bulimic sequences and gradually increase the time devoted to that individual work as her family gives her more room to do that work. Specific elements of this kind of individual work have been described elsewhere and so will not be repeated here (Schwartz, 1987a, 1987b).

CASE EXAMPLE

Sara Smith was an attractive 17-year-old high school junior, an only child, living with her parents. The Smiths were an attractive, personable and articulate family who epitomized the hyper-Americanized family described previously. They came to therapy because Sara's binge/purge cycle was disrupting their otherwise peaceful existence.

Mr. Smith could not understand why Sara couldn't just control herself. He was a great proponent of self discipline and felt very uncomfortable showing vulnerability or being in the presence of those who did. His attitude inculcated in Sara an achievement part that disdained her own weak and vulnerable parts. Similarly, Sara's mother tried to keep a "stiff upper lip" but frequently fell victim to bouts of despair or rage. Because Mr. Smith hated weakness, Mrs. Smith was unable to turn to him for emotional support, and consequently Sara became very concerned about and reactive to her mother's depression. Heated battles between mother and daughter

erupted when her mother was upset, and the focus of these fights was Sara's eating.

As in the hyper-Americanized family pattern described previously, Sara's family was highly male-oriented. Both Sara and her mother valued her father above themselves and competed with each other for his approval. Sara was desperate to keep the approval of her father. Thus her achievement and approval parts became extreme and highly influential. Being thin was a frequent focus of both of these parts because Sara's father (like all other men, she believed) liked his women that way.

This family system created a context for the kind of polarized parts that are commonly found in the internal sequences of bulimics. These included (1) a part that worried about her parents' welfare and told her to be sacrificial, rather than selfish, (2) a part that wanted her to achieve and became highly critical if she did not listen to it or if she acted sad or weak, (3) a part that wanted her to look perfect and which became highly critical of her eating habits, (4) a part that became extremely sad, lonely and helpless since she received little nurturance from her parents, and (5) a part that told her to indulge or that took over and made her binge.

By asking her about these parts and their dialogues in various situations, a symptom-maintaining sequence among them became evident. For example, her father might say something to her about her poor school performance and this slight would activate the achievement part to berate her for being so lazy and worthless. That criticism always stirred up the sad part that would make her feel hopelessly depressed, and at times, suicidal. To protect her from these scary feelings, the indulgent part took over at that point and she would binge. During the binge however, the appearances part reminded her of all the weight she could be gaining and made her vomit. After the episode, the achievement part again began to berate her, this time for being so gluttonous and undisciplined—and that berating would trigger the sequence to repeat, sometimes three or four times a day.

Because Sara was living at home, it seemed appropriate to begin in therapy by addressing issues within the family system first, and then work on her internal family system later in the course of therapy. The initial focus at the family level was on Sara's relationship

with her mother. During sessions, Sara and her mother were encouraged to talk more directly with one another while the father was prevented from interrupting. As the therapist raised questions regarding the way that their family viewed men and women or achievement, and the impact of these views on them, Sara and her mother began to confront their competitive feelings for Mr. Smith's attention, which was difficult but necessary for the improvement of their relationship. In order to facilitate their focus on these issues, a moratorium was declared on the parents' attempts to get Sara to stop bingeing because as long as they were actively fighting over that battle ground, they could avoid these more difficult issues. Gradually, mother and daughter came to see that they could enjoy each other's company.

As his wife's and daughter's relationship improved and they began to do things together, Mr. Smith, who was used to being the center of attention, became increasingly demanding. When his wife and daughter did not revert to competing for his attention, he too had to become more direct in stating his needs. For the first time, he told Sara directly how important it was to him to have his "little girl" near him. And Sara was able to tell him that she could no longer be his little girl and needed to have a life for herself. Such directness laid the groundwork for a more appropriate type of relationship; one in which Sara had the freedom to be the young adult that she was becoming.

Changes in the Smith family affected Sara's internal family system as well. The work with her mother had deactivated the part that worried about her mother's depression since she saw that her mother was strong enough to deal with difficult issues and seemed happier in doing so. The part of Sara that was so concerned with the approval of men, especially her father, also became less dominating and extreme; she came to see her father in a less perfect, more human way. Through this period, her bulimia waxed and waned but no longer was the central focus of her existence.

Individual sessions revealed that while a number of Sara's more extreme parts had calmed down the sequence remained (although less intense). Now her sad parts became less extreme because her critical parts (which told her to reject or ignore the sad part) were less active. Still the indulgent part was activated when Sara became

sad, and thus her bingeing continued. In therapy Sara was encouraged to listen to the sad part, acknowledge its pain, and learn to comfort it. Soon that part became less needy and with Sara's continued attention to it, she experienced less sadness. The indulgent part took over much less often and found a new role in advising her about when and how to have fun, and Sara's bingeing greatly reduced.

After several months of this kind of work with her parts, while simultaneously working with her parents in marital therapy, Sara not only stopped bingeing and purging but also began to eat when she was physiologically hungry rather than emotionally hungry. This is considered an important sign of change because it means that her parts have calmed and are allowing her to experience and trust natural body sensations. Therapy ended after approximately one year. Sara had stopped the bulimic behavior altogether. She is presently enrolled in a college in a neighboring state and appears to be enjoying it and doing well.

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