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Family Therapy in the Treatment of Eating Disorders

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Abstract

It has previously been believed that families had a negative impact in their children's eating disorders. Families were often blamed for the development and preservation of their children's eating disorders. However, within the last decade family therapy has provided evidence for the use of families in rehabilitating children with eating disorders. Additionally, families should actually not be held responsible for the development and preservation, rather viewed as patients as well. One outcome of family therapy, for patients diagnosed with an eating disorders, is the process of bringing the family unit closer together. The current literature review has two goals; first, to explore various family therapies in order to develop further understanding of eating disorders, as well as the gap and limitation within some of the current interventions. Second, is to provide possible suggestions for future research to develop other possible family interventions.

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Introduction

Eating disorders have remained among the most damaging psychiatric illnesses having multifactorial unknown pathogenesis that continue to challenge patients, families, clinicians and researchers alike (Abbate-Daga et. al., 2013; Murray & Le Grange, 2014; Steinhaussen, 2002). The multifactorial nature of eating disorders causing severe disturbance to a person's eating behavior is determined from psychological, social, neurological and biological processes (Murray & Le Grange, 2014). Furthermore, the medical risk for individuals with eating disorders is alarming due to issues that include high mortality rates, the likelihood of suicide and reduced quality of life (Murray & Le Grange, 2014).

Eating disorders occur more often in adolescents than adults but can arise between the ages of seven to 71 (Lask, 2015). A study conducted by Anastasiadou, Medina-Pradas, Sepulveda, and Treasure (2014) showed that early interventions result in better treatment outcomes. In addition, a higher level of burden was noted "amongst caregivers of patients with a longer illness duration" (p. 475). This was noted when patients and caregivers spent more time together and was more prevalent in children with anorexia than bulimia.

Treatment for eating disorders, especially for children with anorexia nervosa, involved repeated hospital stays with a focus on medical, behavioral and psychodynamic interventions for the individual patient rather than the family (Dodge, 2016). In the 1970s, families were believed to be essentially harmful in their children's treatment and were often blamed for the development of the eating disorder (Dodge, 2016; Gelin et. al., 2014). However, the last decade has seen advances in family therapy in the treatment of adolescent eating disorders (Murray & Le Grange, 2014). Families, specifically parents, have been identified as important resources in the

management of their children's eating disorder (Lask, 2015). This paper will look at the evolution of family therapy in the treatment of eating disorders and will examine the development of a recent intervention involving emotion-focused family therapy (EFFT) and eating disorders.

Evolution of Family System Therapy

System theory is defined as an organization that focuses on interactions between objects to create a system that is part of a whole (Carich & Willingham, 1987; Wickel, 2014). A systems approach allows for a comprehensive assessment and intervention to understand person and group interconnections (Massey, 2007). Therefore, when focusing on families, system theory looks at the individual as a part, and the family as a whole; consequently, the individuals make up the whole. Therefore, the goal in system theory for therapy is to gain insight into each member's role as it relates to the functionality of the whole (Massey, 2007; Wickel, 2014).

Family members are related by blood or intention, implying that they are affected by each other (Pinsof, 1992). This means that a change in one person triggers a change in the other members, which in turn affects the original member who changed. An article by Magnavita (2012) describes how system theory provided family psychotherapists a way to conceptualize the relational connection between family members.

In family system therapy, members are asked to identify the role they portray, maintain the structure of therapy, respect one another and stay within their predetermined boundaries (Wickel, 2014). Many forms of family therapy are based on family system theory. Research continues to explore various approaches that employ family involvement with eating disorders (Murray & Le Grange, 2014). The following sections will highlight some of these studies.

Eating Disorder Background

Eating disorders comprise anorexia nervosa, bulimia nervosa and, more recently, binge eating disorder. These mental health problems have been on the increase for young people in affluent societies (Ma, 2008). Eating disorders may have multiple causes and have been connected to obesity, personality traits such as perfectionism and obsession, peer pressure and the Western standard of beauty (Ma, 2008). Eating disorder symptoms vary from self-starvation, purging, bingeing, excessive exercising and overuse of laxatives. These behaviors have detrimental effects on psychological well-being, youth health, schooling, peer relationships and social activities (Ma, 2008). In addition, eating disorders increase family conflict. The journey to recovery from eating disorders varies from individual to individual (Ma, 2008).

Family Function

Family dysfunction was often thought of as a contributing factor in the development of eating disorders. The general functioning of a family refers to the overall health of the family system (Holtom-Viesel & Allan, 2014; Lyke & Matsen, 2013). The role of the family environment in the etiology of eating disorders is unclear, and with the passing of time and the associated concerns being absorbed by the family, it can have a major impact on family life (Le Grange & Eisler, 2009).

Individuals who have an eating disorder tend to suffer from impaired insight, which will affect their willingness to undergo treatment (Gisladottir & Svavarsdottir, 2010). As a result, parental reactions that include criticism, hostility and interference become ways that parents may use to cope with their sick child (Gisladottir & Svavarsdottir, 2011; Ma, 2008). People are often

unsure how to help a family member with an eating disorder. They find it difficult to watch a loved one exhibiting unhealthy food behaviour (Gisladottir & Svavarsdottir, 2010).

Lyke and Matsen (2013) conducted a study on family functioning to determine some of the risk factors for eating disorders. They found that an unhealthy level of affective responsiveness, the extent to which family members are able to experience appropriate affect, was related to general dissatisfaction and social and personal anxiety. Moreover, general family functioning was a predictor of problems in adolescence, but not a predictor related to perfectionism or weight control. The limitation to this study was that it relied on participants' self-reporting. In addition, the participants in this study were Caucasian and exclusively young women. It is possible that these results cannot be generalized to other groups. However, identifying eating disorder risk factors is essential for helping clinicians to design prevention programs and for establishing short- and long-term treatment outcomes (Folse & Krawzak, 2013).

A review of the literature conducted by Holtom-Viesel and Allan (2014) on family functioning across all eating disorders reached certain conclusions. Families affected by eating disorders perceived themselves to be more dysfunctional than control families. The area of dysfunction varied, and little evidence appeared in support of a typical pattern for the dysfunction. Holtom-Viesel and Allan suggested the possibility that the specific area in which a family functions less well prior to the onset of the eating disorder becomes more pronounced when the family is required to cope and adjust to a member with a potentially life-threatening illness.

A literature review was conducted by Anastasiadou et al. (2014) with respect to family caregivers and eating disorders. This study concluded that there was a higher level of burden to

be found among the caregivers of patients with a longer illness duration. The researchers also found some gender differences in their review. Mothers were more emotionally over-involved with children who suffered eating disorders than fathers, who tended to be more critical due to lack of understanding of the illness. This would be consistent with the notion that mothers are usually primarily responsible for providing care for the children and, therefore, would feel more anxious and present with more of a negative feeling. The authors of the review suggested that the association between the duration of the illness and most of the aspects of eating disorders experienced by caregivers is based on phenomena related to the stage of the illness. Some limitations to the review included that there might be some transcultural differences in caregivers' experience regarding a family member with an eating disorder, with less burden experienced in cultures where the young adult is expected to stay longer in the family home.

What remains unclear is the degree to which the family contributes to the eating disorder and the impact of the eating disorder on the family. The underlying familial issues need to be examined during the course of treatment. Family members provide an important source of information about eating, eating behaviors and the child's perception of food and body image (Folse & Krawzak, 2013; Tester & Gleaves, 2005). Now, having a better understanding of some of the problems involving family and eating disorders, it is possible to review some of the various family therapies that have been used.

Current Family Therapy Approaches

Parent Counselling

Carers of family members who have an eating disorder are uncertain about how to help, expressing their burden and need for information. Studies have shown that carers of those with

eating disorders are clinically anxious and/or depressed (Abbate-Daga et al., 2013; Treasure, Whitaker, Todd, & Whitney, 2012). Therefore, the carer's own symptomatology and uncertainty about helping can exacerbate the symptoms and behavior of the individual with the eating disorder. Some carers show adaptive responses by focusing on their own interest or perhaps show maladaptive coping by blaming themselves for contributing to the illness and then perceiving themselves as helpless (Abbate-Daga et. al., 2013).

Parent counselling has been widely recommended and used in eating disorder treatment (Rodgers & Chabrol, 2009). The purpose for parent counselling is to inform, educate and provide emotional support to the patient and the family. The study by Abbate-Daga et. al., (2013) looked at a three-step intervention whereby two weeks prior to treatment, parents participated in a preliminary informative group, then parents were clinically assessed, followed by the parents attending counselling for eight 60-minute sessions. At the end of the study, 43.7 % of the families showed a significant improvement in the ability to cope with their child's eating disorder and in family functioning. Parent counselling helped to improve communication, and it was suggested that the intervention was effective for two reasons: (a) it helped achieve a better way of coping with the eating symptomatology, and (b) it focused the intervention on emotion. The study also found that families with poorer coping abilities responded less to parent counselling therapy, thereby indicating that families with greater resources were more likely to learn adaptive and therapeutic strategies. This outcome indicated that parent counselling could be useful for families with a higher level of functioning. Nevertheless, this should be considered as the first approach for those with fewer resources. The limitation to the study was the lack of comparison with another family treatment approach or with non-specific intervention. In addition, the outcome of the parent counselling was not related to the patient's outcome, and no

information was provided on the child's improvement during or after treatment.

Family-Based Treatment (FBT)

Salvador Minuchin and his colleagues were the first to include parents in the treatment of adolescents with anorexia nervosa (Loeb & Le Grange, 2009). This gave rise to studies conducted at the Maudsley Hospital in London and the strategic family therapy movement, a specific form of family therapy that was called the Maudsley approach (Gelin et. al., 2015). Today the Maudsley approach is better known as family-based treatment (FBT).

FBT has evolved to become the treatment of choice for adolescents with anorexia nervosa and bulimia nervosa (Le Grange & Eisler, 2009; Loeb & Le Grange, 2009). This form of therapy was originally used with adolescents who had anorexia nervosa (Le Grange & Eisler, 2009). FBT emphasizes parents as a resource and empowers families to help bring about the recovery of children with eating disorders. The primary goal is to return children to a normal developmental trajectory consistent with their chronological age (Loeb & Le Grange, 2009), and the purpose is to reduce parental self-blame. FBT externalizes the illness to help remove blame from the child since FBT views the illness as a problem related to the adolescent's decision-making capabilities (Loeb & Le Grange, 2009).

Family-based therapy has three different phases. Loeb and Le Grange (2009) discuss the three phases as follows. In the first phase, parents are told to take charge of their child's eating. The therapist works with parents to develop and refine the technique during an in-session family meal so that the parents may convince their child to take one more bite. The focus is on supporting the parents to promote weight gain in their child. In addition, parents are taught to interrupt symptoms and normalize eating patterns and food choices (Lafrance Robinson et. al.,

2015). Once the child has achieved the minimum level of weight restoration and conflict around eating has been significantly reduced, then control over food consumption is transferred back to the adolescent for phase two of treatment. Parents are supported by the therapist to help reduce supervision, one meal at a time (Lafrance Robinson et al., 2015). In this phase, the therapist and family begin to explore previously set-aside adolescent and family issues outside of the eating disorder. Phase three of FBT focuses on termination, issues with family structure and normal adolescent development. The treatment at this phase explores or moves toward the development of adolescent identity. For children with bulimia nervosa, phase one teaches parents to help their teens to re-establish healthy eating patterns and avoid engaging in binge eating and purge episodes, while phases two and three are similar to those of an adolescent with anorexia nervosa. For children with anorexia nervosa, the initial phase of treatment is characterized by the parents taking full control of the child's eating; with bulimia nervosa, the child is more on a par with their peers in terms of adolescent development, and therefore, phase one for those with bulimia is more about collaboration between the parent and child. Treatment is typically conducted in 20 sessions over a 6-month period.

Outcomes of FBT are between 50 and 75% for weight restoration for adolescents with anorexia (Lafrance Robinson et. al., 2015). Long-term follow-up studies have shown that 60–90% of adolescents have fully recovered four to five years later (Le Grange & Eisler, 2009). Adolescents treated with FBT for bulimia had a higher rate of abstinence from binge eating and purging after treatment and at the 6-month follow-up (Lefrance Robinson, Dolhanty, & Greenberg, 2015).

Loeb and Le Grange (2009) discussed a few limitations of FBT. The treatment was a good predictor for remission in younger children; however, studies have not been able to isolate

other variables such as duration of illness, number of previous hospitalizations and BMI with age. FBT does not address parents who have mental or physical health issues. Moreover, FBT has not looked at children with eating disorders who have experienced emotional, physical or sexual abuse.

Maudsley-Based Multiple Family Therapy (MFT)

Through the years, the Maudsley model has evolved from a single-family practice to a MFT model where the therapeutic method brings together several families (Geln et. al., 2015), basically combining family therapy and group therapy. However, there has been little solid evidence in the literature on the effectiveness of MFT. There are three premises for the evolution to involving multiple families (Gelin et. al., 2015): (a) families have expertise in therapy, and the therapy aims to activate family competence; (b) therapy is limited as to time and (c) relationships are centered in therapy.

Gelin et. al. (2015) described a treatment using three phases similar to the Maudsley model discussed in the FBT section. The purpose of including multiple families in therapy is to encourage parents to adopt more coherent and firm attitudes regarding the eating disorder. This is monitored by the therapeutic team, which may consist of a behavioral cognitive therapist, psychiatric nurses, dietitians, and a psychiatrist. In phase two, family functioning and family intrafamily relationships are considered. Attention is focused on areas of family dissatisfaction prior to the onset of the eating disorder. During the third phase, the emphasis is on the psychosocial and psychological development of each family member. The adolescent is encouraged to become independent and develop good, healthy relationships with parents and other family members.

Gelin et. al. (2015) found that MFT may be effective in the treatment of adolescents with eating disorders. This study showed three important points about alliance in family therapy: (a) the family shared a sense of purpose about the needs, goals and value of therapy; (b) split alliance with the therapist and (c) felt a sense of safety within a therapeutic context. It was additionally noted that an alliance also developed within the family between parents, patients, and siblings. However, the limitation to this study was that there was a lack of control and no comparison group to draw firm conclusions. In addition, there was no follow-up information on how the families were doing post treatment.

The New Maudsley Model

This model addresses the complex needs of individuals with severe-stage anorexia nervosa, as compared to newly diagnosed individuals who do not have time-related effects, either biological or psychological (Treasure, Rhind, MacDonald, & Todd, 2015). Carers are taught how to care for themselves and manage stress reactions related to their loved one's disorder by sharing information, teaching communication techniques and working with a team approach (Treasure et. al., 2015). Carers are taught a "C"-style approach: compassion and co-operation with a collaborative and consistent approach with close ones (Treasure et. al., 2015). In other words, carers are taught how to view their approach to the illness and reduce enmeshment by encouraging their loved one to take responsibility for the agreed-upon boundaries. The skills taught during the treatment are explained to the carers as skills that are used for training professionals (Treasure et. al., 2015). This approach helps to remove the blame from the carers. The workshops are an important element where the therapist acknowledges the enormous burden that carers experience when they have loved ones with anorexia and bulimia.

An article by Treasure et. al. (2015) mentioned that the new Maudsley model teaches communication skills based on motivational interviewing skills to carers during a workshop to encourage their own behavioral changes. Motivational interviewing is based on the belief that we have the ability to change. Carers' energies tend to be focused on issues outside their direct control, such as the refusal of the patient to accept help. Role-playing and observation of recorded interactions allow carers to critique and analyze their own interactions. The authors also mentioned that eating disorders produce intense emotional reactions. Therefore, participants are taught to use animal metaphors to describe the most common reactions in order to separate themselves from emotional reactions and behaviors. Examples include "over-emotional (jellyfish), avoidant (ostrich), critical (terrier), hostile (rhinoceros), and over-protective, avoidant (kangaroo)" (p. 370). The goal is a collaborative and consistent approach, whereby joint behavior changes styles and goals around meal support, reducing accommodation and enabling behaviors.

The new Maudsley model was found acceptable and effective for reducing distress in carers after completion of the program and at the three-month follow-up (Pepin & King, 2013; Treasure et. al., 2015). Carers noted improvement in themselves and in the eating-disordered patient after the intervention (Treasure et. al., 2015). One limitation was that family involvement and individual work needs to be thoughtfully matched to the severity and the stage of the illness.

Emotion-Focused Family Therapy (EFFT)

As mentioned, FBT is currently regarded as the best outpatient treatment model for child and adolescent eating disorders. Lafrance Robinson et. al. (2015) noted that a significant minority does not respond to FBT, indicating a need to target emotion processing and emotion

regulation skills along with refeeding and interruption of symptoms in the early phases of treatment. The researchers asserted that there are a number of factors that make an eating disorder a compelling solution to the management of unwanted negative emotion. For example, symptoms may regulate or soothe the emotional sensations of feeling insecure, unloved, humiliated, trapped or powerless. Starving numbs, binging soothes and vomiting provides relief (Dolhanty & Greenberg, 2007). Therefore, it has become widely accepted that the role of emotion and its avoidance are central in an eating disorder (Dolhanty & Greenberg, 2007; Lafrance Robinson et. al., 2016).

EFFT is a treatment approach for eating disorders based on the key principles of emotion-focus therapy (EFT), which states that emotion is fundamental in the construction of the self (Greenberg, 2010; Lafrance Robinson et. al., 2016). For example, in healthy development, a caregiver's responses to the emotional reaction of a child validates that emotion and provides coaching (Lafrance Robinson et. al., 2015). The aim of EFFT is to enhance the carer's role in treatment delivery using a skill-based approach. Lafrance Robinson et al. (2015) believed that parents can be empowered, as in FBT, and felt that the theory and technique of EFT along with the new Maudsley method of supportive guidance from a therapist can be the intervention needed to improve the outcome of eating disorders. Lafrance Robinson et. al. (2016) stated that EFFT looks at three main domains of interventions when supporting and educating parents: (a) mastering their skills and feelings involved in recovery coaching, (b) mastering emotion coaching and (c) managing emotional blocks.

Lafrance Robinson et. al. (2016) listed four main principles for an EFFT approach.

- **Focus on family:** Patients with eating disorders want to be supported by their parents, no matter their age, and parents want to support their loved ones throughout recovery.

- **Centrality of emotion:** EFFT therapists work with the family to interrupt any patterns of emotion avoidance and provide parents with emotion-processing skills to understand this concept.
- **Importance of parent empowerment:** Self-confidence and strength are central within EFFT. Therapists take on the belief that parents have the ability to have a significant role in their loved one's recovery.
- **Skill development and training:** These are referred to as the advanced caregiving skills that are needed.

There are three phases to EFFT as it is an integration of FBT and EFT, and the three phases are similar to those of FBT. Lafrance Robinson et al. (2015) described the phases as follows. In phase one, the parents are instructed to take charge of the refeeding and interruption of symptoms. The added EFT component is that the therapist begins to identify the parental blocks—the fears and emotional obstacles—that are interfering with the parent's ability to refeed or become the child's emotion coach. The therapist also provides the parents with empathy for their own emotional pain.

In phase two, the parents return control to the child. For the parent, this continues to be a struggle between nurturing the child and working toward eating disorder resolution. In this EFT component, the therapist continues to provide support aimed at increasing the parent's competence and independence from the therapist as the child's coach. The therapist teaches the parent to enhance empathy skills, including the ability to imagine being in the child's experience. The intent for enhancing the parent's empathy is to deepen the parent-child relationship and to

provide effective coping strategies to allow the child to communicate directly with the parent when all is not well, instead of communicating through the eating disorder. EFT intervention serves two purposes: (a) increasing the child's feeling of self-efficacy when experiencing and processing painful emotions and (b) creating a safe space for the child to not blame him- or herself for the onset and development of the illness and for self-reproach regarding what he or she put the family through. If parental blocks continue in phase two, the therapist will progress with more intensive interventions, such as individual counselling with the parent. In dealing with parental blocks at this phase, the animal metaphor as seen in the new Maudsley method is introduced.

In phase three, the family continues to support the child toward the healthy development of adolescent identity. The EFT component in this phase has the parent and child continue working with emotions while the therapist continues to fade out. The child is encouraged to communicate with the parents' fears and feelings. Education is emphasized, along with support in the process of separation and individuation.

There are not many studies with respect to EFFT and eating disorders, but from the study conducted, preliminaries show promise for families who require a more intensive treatment model (Lafrance Robinson et. al., 2015; Lafrance Robinson et. al., 2016). The results showed an improvement in parental self-efficacy with respect to recovery as parents became equipped with the emotion regulation skills necessary to face challenges. However, the study design appears to have some limitations, including a short time between measurement intervals. The other limitation is that there are no follow-up data gathered after the implementation of treatment.

Recommendations and Future Research

From this literature review, some recommendations can be identified for children and adolescents in the use of family therapy. Parental involvement is important and should be incorporated as early as possible and throughout treatment (Gowers & Bryant-Waugh, 2004). Early intervention is important upon diagnosis, rather than waiting for the biological and psychological effects that occur with children and adolescents experiencing longer-term symptoms. Interventions need to be provided based on age-appropriateness, taking into account the child's developmental age (Gowers & Bryant-Waugh, 2004).

Future studies for EFFT as identified by Lafrance Robinson et al. (2016) suggest randomized control design, along with studies that explore various treatment elements and variables such as treatment status, diagnosis and age. In addition, follow-up studies are essential to better understand the long-term outcomes related to interventions.

Abbate-Daga et. al. (2013) mentioned that future studies and randomised controlled trials comparing parent counselling with other family therapy treatment need to be conducted to determine if there are any gaps. Future studies can be conducted to determine if families with lower coping abilities need more counselling sessions and if families with limited economic resources would benefit from shorter interventions involving motivational sessions.

In a systemic review of family caregiving in eating disorders conducted by Anastasiadou et. al. (2014), the authors suggested that future research should focus on the impact of eating disorders on fathers, partners and siblings as these are less studied. Mother–child relationships are studied more since mothers are considered primary carers. The researchers also suggested that there may be some transcultural differences in experiencing eating disorders and caregiving,

with less burden experienced in cultures in which there is more of an expectation that a young adult will remain in the family home for a longer time.

This writer identified a few future studies, as well, while conducting this review. There was information in the research about adult children, attachment theory and EFFT. However, there was no information about attachment theory, EFFT and eating disorders. Therefore, future studies should investigate attachment theory along with eating disorders and family therapy. Furthermore, many of the studies conducted were based upon individuals with either anorexia or bulimia, but very little information was found pertaining to obesity and binge eating disorder (BED). Therefore, future studies should be focused on family therapy in the care of individuals with BED. Additionally, many of the studies did not identify the gender of the child. Therefore, studies should also look at gender of the child related to treatment and outcome.

FBT was identified as a positive treatment approach. However, the studies reviewed here did not discuss issues of parents not wanting to engage in treatment or issues with parents who demonstrated a high level of criticism, or expressed emotion in the family. It might be beneficial to offer the young patient individual treatment options as well, such as cognitive behaviour therapy or interpersonal therapy. Therefore, it would be interesting to conduct studies on families that are resistant or unable to take part in treatments.

Summary and Conclusion

Family is not a static phenomenon, but a process that evolves and transforms over time (Pinsof, 1992). The question remains, how does a family evolve when there are issues involving eating disorders? This review has shown that eating disorders are often a symptom of family problems. Consequently, family therapy has become the treatment of choice for clients with

anorexia nervosa and bulimia. Studies have shown advancement regarding the impact of psychological risk factors, including family dynamics, on the development and maintenance of eating disorders (Folse & Krawzak, 2013). Engaging the patient's family in treatment to address issues that may contribute or maintain an eating disorder has been shown to have a positive effect (Folse & Krawzak, 2013).

All treatment models looked at in this review have shown mechanisms of change such as interpersonal relationships. The results showed that different treatments had similar results and successes, along with lack of success. The question remains whether it is possible to treat all those with eating disorders with one intervention for the entire population, or if it is possible that our understanding of family intervention in bringing about change continues to be a mystery, which remains to be further explored in future studies. This review did provide the crucial understanding that, no matter the treatment of choice used, families are part of the solution and not the problem.

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