The Role of Families in the Treatment of Eating Disorders in Adolescents:

an Analysis of Family-Based Models

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Abstract

Eating disorders indicate a significant degree of psychological impairment among adolescents. In addition, family members of relatives with eating disorders experience difficulties that result in high levels of distress. This paper presents a general overview of the theoretical and research literature that explores family therapy for the treatment of eating disorders in adolescents as well as the Adlerian perspective and treatment of eating disorders. Family-based treatment models specifically designed and recommended for anorexia nervosa and bulimia nervosa along with treatment models sufficient for all of the eating disorders will be discussed. These treatment models offer guidance and support to reduce eating disorder symptoms in the adolescent, and to promote positive communication and relational skills within the family system.
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The Role of Families in the Treatment of Eating Disorders in Adolescents: 
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Eating disorders entail complex and very serious mental and behavioral disorders as well as psychiatric and medical problems (Le Grange, Lock, Loeb, & Nicholls, 2010). They have the highest mortality rate of all mental illnesses (Clarke & Polimeni-Walker, 2004) and affect both women and men of diverse cultural and demographic backgrounds. According to the National Institute of Mental Health, “an estimated .60 percent of the adult population in the U.S. will suffer from anorexia, 1.0 percent from bulimia, and 2.8 percent from a binge eating disorder” (“The Numbers Count,” 2011, p. 3). While males account for 10 to 15 percent of individuals with eating disorders (Keel & Haedt, 2008), adolescents make up the majority of individuals with eating disorders. The normal age of onset ranges between 12 and 25 years and peaks between ages 14 and 18. A good prognosis normally requires early detection, skilled medical management, and timely involvement in a comprehensive treatment plan (Clarke & Polimeni-Walker, 2004). Unfortunately, few adolescent patients seek treatment on their own (Sim et al., 2004). Sim et al. (2004) explain that adolescents often harbor denial about the seriousness of their disorder and that patients’ lack of motivation for change results in obstacles for all involved.

Eating disorder researchers in the United States have conducted the majority of their research on females, as “approximately 7-10 million women across the country suffer from eating disorders,” while as many as a million men suffer from these serious disorders (“Males and Eating Disorders,” n.d., para. 1). Researchers, however, indicate that eating disorders in males are clinically similar to eating disorders in females. Men give in to cultural and media pressures for the ‘ideal body’ (“Males and Eating Disorders,” n.d., para. 2). Body image concerns appear to be one of the strongest variables in predicting eating disorders in men. Men
involved in certain athletic activities appear to be at a greater risk for developing eating disorders due to the weight restrictions necessary to compete, such as: body builders, wrestlers, dancers, swimmers, runners, rowers, gymnasts, and jockeys (“Males and Eating Disorders,” n.d.).

One of the central features of eating disorders includes a severe disturbance in eating behavior. The American Psychiatric Association (DSM-IV-TR) classifies two specific diagnoses of eating disorders: Anorexia Nervosa and Bulimia Nervosa (2000). Individuals with anorexia nervosa usually display a pronounced fear of weight gain and dread becoming fat even though they are markedly underweight (“Diagnoses of Eating Disorders,” n.d., para. 2). These individuals maintain a body weight below a normal level for their age and height, which the American Psychiatric Association references as “85% of that expected” (DSM-IV-TR, 2000). The two different types of anorexia nervosa include the restricting type where the person “has not regularly engaged in binge-eating or purging behavior (p. 589)” and the binge-eating/purging type where the person regularly engages in binge-eating or purging behavior to include self-induced vomiting or the misuse of laxatives, diuretics, or enemas (DSM-IV-TR, 2000).

Individuals with bulimia nervosa regularly engage in discrete periods of overeating and then attempt to compensate for their indulgence to avoid weight gain (“Diagnoses of Eating Disorders,” n.d., para. 5). The American Psychiatric Association recognizes two subtypes of bulimia nervosa (DSM-IV-TR, 2000). In the purging type of bulimia “the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas” (DSM-IV-TR, 2000, p. 591). In the nonpurging type the person engages in other “inappropriate compensatory behaviors, such as fasting or excessive exercise, but does not regularly engage in self-induced vomiting or the misuse of laxatives, diuretics, or enemas” (DSM-IV-TR, 2000, p. 591).
Individuals with a diagnosis of bulimia nervosa do not meet the criteria for anorexia and fall within a normal body weight (“Diagnoses of Eating Disorders,” n.d.).

Numerous variations of disordered eating do not meet the diagnostic criteria for anorexia nervosa or bulimia nervosa but still require treatment (“Diagnoses of Eating Disorders,” n.d.). The American Psychiatric Association (DSM-IV-TR) provides a code for disorders that do not meet criteria for a specific eating disorder: The code EDNOS for Eating Disorder Not Otherwise Specified applies when an individual meets all criteria for anorexia nervosa or bulimia nervosa except one, or if individuals have a binge-eating disorder where they regularly engage in binge eating without the use of inappropriate compensatory behaviors (2000). Binge eating falls under the category of Eating Disorder Not Otherwise Specified even though it is not an officially recognized eating disorder (“Diagnoses of Eating Disorders,” n.d.).

In the middle of the 20th century, a significant shift emerged in the outlook of the role of the family’s involvement in the treatment of eating disorders in adolescents. The importance of family support and the possible “detrimental role of parental inaction in the face of a child’s life-threatening malnutrition were first introduced in the accounts of AN [anorexia nervosa] in the late 19th century” (Le Grange et al., 2010, p. 1). Treatment during this time required very limited parent-child interaction in order to prevent enabling of the illness by the parents. In the 1960’s, Salvador Minuchin reframed the role of the family, in what many hailed as a “fundamentally new conceptual model of AN” (Le Grange et al., 2010, p. 1). His model profoundly influenced and advocated a specialized form of family therapy.

Another shift occurred in late 1970’s with regards to family therapy in the treatment of adolescents with eating disorders. Work at the Maudsley Hospital in London “directed attention away from models that presumed a central etiologic and maintaining role for family dynamics to
see the family as a potential resource in therapy” (Le Grange et al., 2010, p. 2). This new outlook helped to ease parents’ burden of guilt by promoting an attitude of inclusion in the family therapy. Current family therapy models for anorexia and bulimia now focus more on assisting family members with developing skills to enhance communication and better negotiate differences (Le Grange et al., 2010).

Numerous studies investigated the effects of parenting and family functioning variables in predicting later onsets of eating disorders or eating related psychopathology and failed to find such factors as significant (Le Grange et al., 2010). The Academy for Eating Disorders upholds a strong position that although “family factors can play a role in the genesis and maintenance of eating disorders, current knowledge refutes the idea that they are either the exclusive or even the primary mechanisms that underlie risk” (Le Grange et al., 2010, p. 1, para. 1). Researchers believe that many risk factors including genetic, developmental, psychological, and cultural influence susceptibility to eating disorders (Le Grange et al., 2010).

Unfortunately, past and current research on eating disorders primarily focused on the role of the family in causing or contributing to the eating disorder, which remains unproven (Le Grange et al., 2010). Fewer research studies exist for family therapy for bulimia nervosa compared with anorexia nervosa (Lock & Le Grange, 2005). The majority of the studies on family therapy for bulimia nervosa focus mainly on adults with bulimia. On a positive note, more recent research reveals that adolescents with bulimia respond favorably to family treatment, therefore, growth in this area appears promising (Le Grange et al., 2010).

Family-based approaches for treating eating disorders gained support in recent years as an alternative to traditional therapy (Sim et al., 2004). Family therapy aims to provide family and loved ones with education, support, communication skills, and conflict resolution skills.
Engel et al. (2007) explain other aspects of family therapy including teaching loved ones how to respond without trying to control or protect the sufferer, teaching members how to have realistic expectations of one another, and reorganizing faulty roles and dysfunctional boundaries. The family therapist teaches appropriate ways of communicating expectations and encourages a strong, united, and supportive parenting team (Engel et al., 2007).

**Family Therapy for Eating Disorders**

Eating disorders not only affect the individuals who suffer from them, but the sufferer’s family as well (“Family Therapy and Eating Disorders,” n.d., para. 1). Family members often experience pain and strong emotions while feeling powerless to help their loved one suffering from an eating disorder (Engel et al., 2007). Given that an adolescent’s eating disorder impacts other family members and can disrupt the family’s daily routines, holidays, and vacations, family members often experience pain and strong emotions while watching the sufferer and tend to feel powerless (Engel, Reiss, & Dornbeck, 2007). Although family members do not cause an eating disorder, they can “unintentionally block the road to recovery” (“Keeping it All in the Family,” n.d., para. 2, p. 1). Therefore, when the entire immediate family participates in treatment focused on discovering these roadblocks and developing ways to overcome them, family therapy can prove successful (“Keeping it All in the Family,” n.d.).

Family members have the potential to be highly instrumental in an individual’s recovery. Family therapy entails more than the individual recovering from an eating disorder. It involves the “efficient functioning and growth of the family unit as well” (“Family Therapy and Eating Disorders,” n.d., para. 1, p. 1). Family therapy intends to treat everyone in attendance. Whether they want to or not, families must make changes in order to accommodate the needs of the
sufferer in attempting to get well. Family therapy sessions promote this growth and change ("Family Therapy and Eating Disorders," n.d.).

A consistent finding in research reveals that family involvement appears useful in reducing both psychological and medical morbidity associated with anorexia and bulimia nervosa (Le Grange et al., 2010). Additionally, Le Grange et al. (2010) explain that family treatment proves acceptable to both parents and patients. While many different types of family therapy exist to treat eating disorders, researchers highly recommend family therapy where the entire immediate family participates (Engel et al., 2007). For the family, it can provide a window into the complex struggle their loved one experiences in an eating disorder ("Keeping it all in the Family," n.d., para. 3). For the patient, family therapy helps them work through triggers to which the family may unknowingly contribute and helps solve these issues ("Keeping it all in the Family," n.d., para. 3).

Family therapy consists of short-term treatment lasting only a few months. Therapy sessions provide family members with the tools necessary to offer constant support to their loved one, prepare and plan nutritious family meals, monitor their loved one’s eating and food behaviors, and strive to heal any underlying issues that may hinder the progress of their loved one’s recovery ("Family Therapy and Eating Disorders," n.d.). Families also learn effective communication skills, reflective listening, conflict-resolution, anger management, healthy boundaries, interpersonal risk-taking, authenticity, and emotion regulation skills ("Keeping it All in the Family," n.d., para. 4). An individual can start family therapy while in a hospital or residential treatment center or in an out-patient treatment. Trained and qualified therapists with an interest or expertise in eating disorders conduct therapy ("Family Therapy and Eating Disorders," n.d.).
Therapists recommend and utilize family therapy especially in the treatment of eating disorders among adolescent populations (Lock & Le Grange, 2005). Eisler (2005) highlights how past research by Minuchin revealed that adolescents suffering from anorexia nervosa “generally do well when the main treatment is family therapy, often without the need for inpatient treatment” (p. 106). Additionally, Eisler (2005) mentions two other studies that propose family therapy as the treatment of choice for adolescent anorexia nervosa. Research reveals that not all individuals suffering from eating disorders will engage in family therapy as part of their treatment plans. Individuals who live in the family home tend to particularly benefit from this type of therapy (“Family Therapy and Eating Disorders,” n.d., para. 6). Overall, research reveals that family therapy may lower relapse rates and enhance recovery for eating disorder patients by helping families cope with an eating disorder together (“Keeping it All in the Family,” n.d., para. 6).

Family-Based Treatment Models

Family treatment models for eating disorders continue to grow and advance. These models share a common characteristic: to evoke change and bring growth and healing, whether it is for the individual, the family, or both. The Maudsley Model remains one of the most well known models for treating anorexia nervosa. Developed in the 1980’s, the Maudsley Model serves as an integration of a variety of family therapy models (Rhodes, Brown, & Madden, 2009). Other common family-based treatments for anorexia, which are incorporated in this analysis, include Manualized Family-Based Treatment, Conjoint Family Therapy, and Separated Family Therapy.

Family-based treatment (FBT) remains an effective treatment for adolescent anorexia nervosa, although it receives little attention for adolescent bulimia nervosa. Recent research
findings, however, suggest that family-based treatment is a promising treatment for adolescent bulimia nervosa, as demonstrated later in this paper (Lock, Le Grange, & Crosby, 2008). Additional research on family-based treatment for bulimia proposes a family-based treatment method as an “appropriate and efficacious treatment for single-parent families as well as two-parent families” (Doyle, McLean, Washington, Hoste, & Le Grange, 2009, p. 153). Successful outcomes in the treatment of adolescents with bulimia usually require parental involvement (Le Grange, 2010).

The multifamily therapy group maintains a common family treatment approach used for both anorexia and bulimia. Relational/cultural theory asserts that “the main healing power of an eating disorders psychoeducational multifamily therapy group comes from the sense of mutual empathy and empowerment experienced within its diverse therapeutic social network” (Tantillo, 2006, p. 82). A psychoeducational multifamily therapy group helps families and patients to experience a sense of cohesiveness as they realize that they are not alone in their experience of the illness and recovery process (Tantillo, 2006). The family meal program and the Aachen Program, a psychoeducational group aimed at the parents of inpatients with eating disorders, remain as common family-based treatment models efficient with clients with anorexia, bulimia, and other eating disorders, along with their families. (Holtkamp, Herpertz-Dahlmann, Vloet, & Hagenah, 2005)

**Treatment Models for Anorexia Nervosa**

**The Maudsley model.** Researchers at the Maudsley Hospital in London developed the Maudsley model, a highly practical treatment approach specifically tailored to the needs of adolescents with anorexia nervosa (Lock & Le Grange, 2005). The Maudsley model of family-based treatment for anorexia nervosa serves as an integration of a variety of family therapy
models (Rhodes et al., 2009). The model follows the perception that “where an eating disorder started matters little in its treatment” (“Types of Treatment,” n.d., p. 5), specifically because it is still unclear as to what causes anorexia nervosa (Lock, 2001). The starting point of the Maudsley model intends for people to stop playing the blame game, and instead, for all members of the family to accept responsibility in treating the problem (“Types of Treatment,” n.d., p. 5). The Maudsley approach puts patients and parents into a mutual place to battle the eating disorder together, in an understanding, caring, nurturing way that addresses significant issues (“Types of Treatment,” n.d., p. 6).

Studies of the Maudsley method demonstrate that for adolescents, this family-based treatment proves “superior to individual therapy and that five years after treatment its advantages continue to be evident” (Lock, 2001, p. 5). The Maudsley model views the family as its key to success. Therapists of the Maudsley model consider the family as the most important resource of this approach. Therapists aim to empower the family to take responsibility for nurturing their ill child back to health (Lock, 2001). Furthermore, therapists encourage parents to take an “authoritative stance against an externalized anorexia nervosa” and work together to stand up to anorexic behaviors (Rhodes et al., 2009, p.181). Additionally, siblings provide emotional support to the patient during this process (Rhodes et al., 2009). Therapists aim to place the family in a “therapeutic bind”: On one side, the family learns about the importance to take immediate action to prevent their child from getting worse, while on the other hand, the therapist communicates acceptance, warmth, and expertise to support the family (Lock, 2001).

The Maudsley model includes three phases of intervention. Common goals include turning back responsibility for eating to the patient and working on a healthy restoration of normal adolescence, including socialization and dating (Rhodes et al., 2009). In the first phase,
which usually lasts for ten or more sessions (Rhodes, 2003), treatment focuses exclusively on the refeeding of the patient (Lock, 2001). Lock (2001) highlights focusing on engaging the family and empowering them to re-feed their child as a key to this phase. Rhodes mentions the importance that, “children who are malnourished because of conversion disorders, food phobias or obsessive compulsive disorders are excluded from the Maudsley model of treatment” (2003, p. 192). In order to provide support to the patient during the refeeding process, the therapist attempts to align the patient with any involved siblings while also reinforcing to the family that the parents did not cause the illness (Lock, 2001).

The second phase of the Maudsley model, which lasts between two and six sessions, includes the refeeding task. Responsibility turns back to the patient when steady weight gain becomes evident (Rhodes, 2003). Lock explains that the therapist focuses on encouraging the parents to help their children take more control of eating on their own. The third phase begins when the patient maintains a stable weight without significant parental supervision (Lock, 2001). In this phase, which lasts approximately four sessions, patients take over complete control of their eating (Rhodes, 2003). Treatment then focuses on the “impact anorexia nervosa has had upon establishing a healthy adolescent identity” (Lock, 2001, p. 5). Finally, as Lock explains, this phase works toward increased personal autonomy for the adolescent and on more appropriate family boundaries.

The Maudsley model elaborates on several of the strengths from the history of family therapy. Common approaches incorporated into the Maudsley model include Minuchin’s structural approach as well as other modern and postmodern influences (Rhodes, 2003). According to Lock, “family-based treatment based on the Maudsley model is the most promising treatment now available for helping adolescents with anorexia nervosa” (2001, p. 6). Studies
reveal the Maudsley model proves successful and more superior than individual therapy with outcomes maintained at a 5-year follow-up. With the risks of death as a result of complications of anorexia at an estimated 6 to 15 percent (Lock, 2001), the Maudsley model meets an immense need for such a well-researched and supported form of treatment.

**Manualized family-based treatment.** Manualized family-based treatment proves as another successful treatment for anorexia nervosa. Numerous studies reveal that adolescents with anorexia nervosa benefit from family participation in their treatment (Krautter & Lock, 2004). These family psychotherapeutic treatments continue to become more manualized, meaning they utilize a “manual-driven family-based treatment for anorexia nervosa” (Krautter & Lock, 2004, p. 66). The need to replicate the Maudsley approach in other settings drove the decision to create such a treatment manual (Lock & LeGrange, 2001). Krautter and Lock (2004) declare manualized therapies as “fundamental to systematic psychotherapy treatment research” (p. 67). Although many clinicians hesitate to embrace them, claiming the treatments lack sensitivity to the unique needs of particular patients. Contrary to the clinicians’ reluctance, manuals prove particularly helpful to therapists and patients by assisting in defining treatment goals, timing interventions, and providing an overall structure to the treatment (Krautter & Lock).

Researchers at the Maudsley Hospital in London first developed a manualized form of family-based treatment for anorexia nervosa in 2001. Krautter & Lock (2004) explain that this treatment requires a strong family commitment and effort as well as acceptance of the approach by the patient. Manualized family-based treatment ranges from six to twelve months, with an average of fourteen sessions over a period of nine months of treatment. Initial sessions meet
weekly and then taper to every other week and eventually to once a month (Krautter & Lock, 2004).

The manualized family-based therapy for anorexia nervosa shares similarities with the Maudsley model in that it proceeds through three clearly defined phases. The first phase focuses on correcting severe malnutrition associated with anorexia nervosa through parents taking charge of feeding their child. Krautter and Lock (2004) explain that this phase includes a family meal which allows the therapist to observe the families’ interaction patterns around eating and aims to establish and reinforce a strong parental alliance around eating, while also attempting to align the patient with any siblings. In the second phase of manualized family-based treatment, parents help their children to take more control over their own eating under the parents’ supervision. The final phase focuses on the impact anorexia inflicts on a healthy adolescent identity and reviews pertinent issues of adolescence including supporting increased personal autonomy for the adolescent, familial boundary management, and supporting parental focus on their life as a couple (Krautter & Lock, 2004).

Krautter and Lock (2004) highlight studies of manualized family-based therapy which reveal that “78% of participants felt highly positive about family treatment” (p. 72). Reports with patients show some of the most helpful aspects of this approach as having the whole family included in the treatment, the refeeding process, separating the illness from the patient, learning better ways to communicate, education about the seriousness of the illness, and increased parental understanding. Reports reveal some of the least helpful aspects about manualized family-based treatment as a lack of an individual therapy component and no parent support group as well as its short duration. Families reported several positive changes including increased family closeness, increased communication, increased openness and honesty, increased problem-
solving skills, increased parental understanding, increased family support and patience to name a few (Krautter & Lock, 2004). Nevertheless, manualized family-based therapy for anorexia nervosa continues as a highly effective, promising treatment acceptable to adolescents and their parents.

**Conjoint family therapy and separated family therapy.** Studies continually evaluate the effectiveness of various forms of treatment. Growing evidence suggests family therapy as an effective treatment for adolescent anorexia nervosa (Eisler, Simic, Russell, & Dare, 2007). Two common forms of outpatient family therapy, conjoint family therapy and separated family therapy, confirm the efficacy of family therapy for adolescent anorexia nervosa, showing that “those who respond well to outpatient family intervention generally stay well” (Eisler et al., 2007, p. 552). Conjoint family therapy and separated family therapy continue as successful outpatient family treatments for anorexia nervosa. While studies reveal relatively similar end of treatment results, two main findings differentiate them: For patients from families with high levels of maternal expressed emotion, separated family therapy proves superior to conjoint family therapy, and on measures of individual psychological change, studies show significantly more improvement in patients who receive conjoint family therapy (Eisler et al., 2007). Nevertheless, results report both family-based treatments as effective in adolescent anorexia patients (Paulson-Karlsson, Engstrom, & Nevonen, 2009).

In the initial family sessions for both conjoint family therapy and separated family therapy, therapists provide families with information about the physical and psychological effects of self-starvation over which the patient often retains little control (Paulson-Karlsson et al., 2009). While both treatments remain somewhat similar, the major difference between the two exists in the format of actual therapy. In conjoint family therapy, adolescents meet with the
therapist together with their family, while in separated family therapy, adolescents meet with the
therapist separately and their family members meet with the same therapist at another time
(Eisler et al., 2007). Studies on conjoint family therapy and separated family therapy confirm the
efficacy of family therapy for adolescent anorexia nervosa. Paulson-Karlsson et al. (2009)
explain how therapists encourage parents to fight against the illness and not their loved one.
Studies show that those who respond well to outpatient family intervention generally stay well
(Eisler et al., 2007).

In conjoint family therapy the whole family meets with the therapist together throughout
the duration of treatment. In separated family therapy the adolescent sees the therapist
individually while the parents attend separate sessions with the same therapist (Eisler et al.,
2007). Both conjoint family therapy and separated family therapy last for a duration of about 12
months, with weekly sessions for the first six months followed by bi-weekly sessions for the
remaining six months (Paulson-Karlsson et al., 2009). In comparing the two treatments, Eisler et
al. (2007) report no differences in the long-term outcome of both family therapies. Eisler et al.
suggest the most encouraging finding as a generally good outcome for the majority of patients in
both conjoint family therapy and separated family therapy, with 75% of the subjects reporting no
eating disorder symptoms at a five year follow up study.

**Treatment Models for Bulimia Nervosa**

**Family-based treatment.** Researchers praise efforts of family-based treatment for
anorexia nervosa, but give much less attention to its counterpart for bulimia nervosa (Lock, Le
Grange, & Crosby, 2008). Treatment for bulimia nervosa remains crucial as it continues as a
highly prevalent disorder affecting 1-5 % of adolescent girls in the United States (Le Grange et
al., 2003; Doyle et al., 2009). Since bulimia nervosa occurs even more frequently than anorexia
nervosa, researchers essentially realized the great need for investigating successful treatment options for bulimia nervosa (Le Grange, Lock, & Dymek, 2003). Family-based treatment originated and proves extremely successful with treatment for anorexia nervosa; therefore, researchers deem it an effective and promising treatment for bulimia as well (Lock et al., 2008). Le Grange et al. (2003) highlight how researchers also replicated the successful family component from treatment with anorexia nervosa into therapy for bulimia nervosa. Similar to treatment for adolescents with anorexia nervosa, individuals with bulimia nervosa still living with their family of origin prove to benefit the most from family-based treatment for bulimia (Le Grange et al., 2003).

Family-based treatment for bulimia occurs on an outpatient basis ranging an average of six months in length (Lock et al., 2009). Family-based treatment for bulimia nervosa acts as a problem-focused treatment that relies on behavioral change directed by parents as the main strategy. Therapists strongly emphasize family involvement as a significant resource in helping to reduce binge eating and purging behaviors (Doyle et al., 2009). Essential goals of family-based treatment for bulimia nervosa include fostering a collaborative effort to empower parents and the adolescent to disrupt restrictive dieting, binge eating and purging or any other distorted weight control behaviors (Le Grange, 2010). Le Grange (2010) highlights another common goal which aims to externalize the illness, that is, to “separate the disordered behaviours from the affected adolescent” (p. 66). Similar to family-based treatment for anorexia, parents help their child restore healthy eating habits and then return this control over to the adolescent. While parents actively address their child’s eating disorder symptoms, any siblings involved offer support to their affected sibling in areas that do not involve mealtimes (Le Grange, 2010).
Another major similarity family-based treatment for anorexia shares with family-based treatment for bulimia involves the use of three phases. The first phase of treatment for bulimia focuses on re-establishing healthy eating for the adolescent. The first phase entails 10 sessions, with the entire family present for the majority of each session (Le Grange, 2010). A key component of this phase involves the family meal. Le Grange (2010) highlights how therapists observe the “familial interactions around eating” (p. 169) and encourage parents’ direct involvement with their child’s recovery. Lock et al. (2008) explain that the first phase focuses on negotiating parental control over eating and weight-related behaviors. Additionally, therapists help the adolescents put into words some of their internal anguish and shame about their eating and weight concerns (Le Grange, 2010).

The family meal allows the parents to re-establish healthy eating and regular healthy meal consumption with no binge eating or purging. Parents bring a meal to session that their family would typically eat for lunch or dinner (Le Grange, 2010). In addition, Le Grange highlights how adolescents share with their parents a list of their ‘forbidden’ or ‘trigger’ foods (p. 169). Therapists assist parents with encouraging their child to eat some of these feared foods because a ‘forbidden’ foods list does not set the tone for healthy eating patterns (Le Grange, 2010).

The second phase involves returning control over eating back to the adolescent. Therapists determine the shift from phase one to phase two through a detailed inquiry at each session about the families’ meal times (Le Grange, 2010). Le Grange mentions that as long as mealtimes are occurring without the earlier tensions and anxieties, the therapist will make a clinical judgment to advance to the next phase. Adolescents now have freedom to make their own food choices, but the parents continue to “assist the adolescent should it appear that some
choices are still influenced by the eating disorder” (Le Grange, 2010, p. 171). Throughout this phase, parents also attempt to reinforce healthy peer relationships for the adolescent (Le Grange, 2010).

The third and final phase of family-based treatment for bulimia nervosa focuses on adolescent developmental issues and termination. Le Grange (2010) mentions how the focus shifts from the absence of binge eating and purging more towards specific issues pertaining to adolescent development processes. Therapists schedule meetings every third week because this phase serves as more of a review of issues than an in-depth discussion attempting to resolve issues. The central theme remains to establish a healthy relationship between the adolescents and their parents, working toward increased autonomy for the adolescent and reinforcing healthy family boundaries (Le Grange, 2010). Two models of family-based treatment for bulimia nervosa exist: one for single-parent families and one for two-parent families (Doyle et al., 2009).

**Family-based treatment with single parent families.** Clinicians originally designed family-based treatment for bulimia nervosa with the intention of two parents engaging in the treatment. They explain how the adolescent’s family serves as a significant resource for helping the client to normalize his or her eating and return to health. Although no current research supports the claim that single-parent families have poorer outcomes in family-based treatment for bulimia, some evidence suggests that family status may relate to treatment outcomes. Single-parent families may have less time, fewer social supports, or fewer financial resources than two-parent families which could decrease their ability to provide adequate parental monitoring (Doyle et al., 2009).

Researchers propose that sharing parenting responsibilities across two caregivers would allow parents to better provide the flexibility, support, and consistent supervision needed in
family-based treatment for bulimia nervosa (Doyle et al., 2009). Doyle et al. (2009) highlight a survey of therapists specializing in marriage and family therapy which reveals that the “majority of therapists believe that the traditional, two-parent family structure is intrinsically more health promoting for children than single-parent families” (p. 154). Other research suggests that therapists could hold a bias against non-traditional families in which parents and children are not biologically related or when neither parent is at home with the child (Doyle et al., 2009).

Doyle et al. (2009) highlight a study which compared two-parent and single-parent families on demographic variables, presence of comorbid psychiatric illnesses, and symptoms of bulimia nervosa at baseline, post, and six month follow-up. Results revealed no significant differences between two-parent and single-parent families on any variables (Doyle et al., 2009). Doyle et al. state that patients in both the two-parent and single-parent groups “showed significant reductions in eating disorder behavior and depressive symptoms as well as increases in self-esteem” (2009, p. 156). A couple of limitations noted include the possibilities of two-parent families not sharing responsibilities equally or single-parent families recruiting significant assistance from other family members or friends. Despite any speculations or limitations, results suggest that family-based treatment remains an appropriate and efficacious treatment for single-parent as well as two-parent families (Doyle et al., 2009).

Like other forms of family treatment for eating disorders, family-based treatment for bulimia nervosa assures that families do not cause eating disorders (Doyle et al., 2009). Doyle et al. (2009) explain that the aim of this treatment remains to “externalize and separate the symptoms of bulimia from the affected adolescent to promote parental action and encourage adolescent cooperation” (p. 153). Research reveals that individuals from single-parent families benefit more from a long term treatment, averaging around 12 months. Despite any differences
among treatment for single parent and two-parent families, studies suggest that family-based treatment for bulimia nervosa proves an appropriate and successful treatment (Doyle et al., 2009).

**Family-Based Treatment Models for All Eating Disorders**

While specific treatment formats exist to treat individuals with anorexia nervosa or bulimia nervosa, researchers enacted models to benefit and treat individuals exhibiting any of the eating disorder symptoms or diagnoses. No consistent structure or pattern exists regarding functioning in families with a member who suffers from an eating disorder (Le Grange et al., 2010). Le Grange et al. (2010) encourage families to become routinely involved in the treatment of their loved ones, regardless of the type of eating disorder they exhibit. An individual’s treatment and the families’ involvement varies from family to family, therefore, a number of family treatment options exist to best suit the individual and families’ lifestyle.

**Family meal program.** A common form of family treatment for use with any of the eating disorders involves meal support training or a family meal program. Patients and families involved in eating disorder treatments often report stress and challenges pertaining to mealtimes (Leichner, Hall, & Calderon, 2005). Family meals in the treatment of eating disorders originated with the intention of developing a therapeutically induced family crisis (Jaffa, Honig, Farmer, & Dilley, 2002). Leichner et al. (2005) highlight recent research on the experience of caring for a person with an eating disorder which “identified the need for information, practical advice, and guidance on how to interact with the person in a helpful manner” (p. 407). Leichner et al. (2005) explain that “guides or manuals written to provide information and strategies for parents to help them with their ill youth rarely address mealtimes in detail” (p. 407). Researchers wrote a
Meal support provides emotional support to a person struggling with an eating disorder before, during, and after meals and snacks, attempting to increase the individual’s success with meal completion (Leichner et al., 2005). Leichner et al. (2005) explain that meal support helps a broad range of patients including those who struggle with “restricting food intake, binge eating, purging behaviors, over-exercising, and self-harm behaviors” (p. 408). Meal support entails numerous goals for the patient: to “normalize eating behavior, facilitate weight gain or weight maintenance, re-introduce eating as a pleasant social experience, increase self-confidence around healthy food intake, and decrease rituals around and fears of food” (Leichner, et al., 2005, p. 408). An emphasis on family involvement remains prevalent throughout the process (Jaffa et al., 2002).

The family meal program begins with discussions between therapists, the patient, and the family. Jaffa et al. (2002) explain how therapists will discuss with the parents “what to expect regarding the amount of food the patient is currently eating, how long they are taking, and what unusual behaviours they may exhibit (e.g. if they pick their food apart, or cut up items into tiny portions)” (p. 203). Some patients have not eaten with their family for a long time and most will have experienced stress or conflicts and report anxiety over eating with their family. Ideally, the family meal program begins with the patient still enrolled in an in-patient setting, with the meals initially eaten at the treatment facility. As treatment progresses, the program extends to meals eaten at home and then in other settings such as with extended family or in restaurants (Jaffa et al., 2002).
Family members involved in the meal support program should not exhibit a negative self-image related to weight or have a fear of certain foods. Additionally, diet foods must not present a part of any of the meals. After the family eats a meal together, with the patient still involved in an in-patient setting, the therapist meets with the parents and the patient to reflect on the events of the meal. The therapist encourages the patients to offer feedback of what they found helpful about their parents’ input and what they would prefer done differently. The therapist then asks the parents to describe their experience of the meal (Jaffa et al., 2002). Jaffa et al. (2002) mention how the therapist continually aims to keep open lines of communication so the patient can help the parents to support them more effectively.

Throughout the family meal program, therapists provide encouragement and assist patients and their families if they become stuck or challenged in any way. Family members take on the role as supportive helpers to the individual in recovery. Therapists provide the family with a practical manual and video to guide them in supporting their loved one with an eating disorder (Jaffa et al., 2002). The family meal program serves as a core component to eating disorder treatment and provides a predictable structure for healthy eating during meal times (Leichner et al., 2005).

**Aachen program for Anorexia and Bulimia.** The Aachen program represents another successful family treatment used to treat any of the eating disorders. The program entails a group psychoeducation program for parents of adolescent patients with eating disorders. Therapists often notice how the development of an eating disorder within a family can trigger strong emotional reactions (Holtkamp et al., 2005). According to Holtkamp et al. (2005), parents experience feelings such as guilt, shame, and anger; they tend to blame themselves for not having recognized the disease soon enough. Holtkamp et al. highlight studies of families which
“demonstrated an increased incidence of various forms of mental health problems such as depression and anxiety disorders, in mothers and other first-degree relations of patients with eating disorders” (p. 382). The family’s attention shifts increasingly to the eating disorder and to the adolescent suffering from it (Holtkamp et al., 2005).

Compelling research finds that the impact of dysregulated behavior and the overall specific caregiving problems occur less if the individual with an eating disorder does not live at home (Sepulveda, Whitney, Hankins, & Treasure, 2008). Dysfunctional behavior within the family creates problems since the atmosphere in the family influences the treatment of eating disorders (Holtkamp et al., 2005). While the parents or family members do not represent the cause for the development of eating disorders, “they are regarded as important resources in the treatment and are instructed accordingly” (Holtkamp et al., 2005, p. 383). This proves especially relevant in the phase of weight rehabilitation in which many young patients have no control over their eating behavior (Holtkamp et al., 2005).

According to Holtkamp et al. (2005), the Aachen program serves to provide parents with detailed information through group psychoeducation about eating disorders and treatment. Typical group leaders include a child and adolescent psychiatrist, a nutritional scientist, and an occupational therapist specialized in eating disorders. Therapists involve parents in five 90 minute sessions aimed at increasing their understanding of the eating disorder in hopes that it will prove helpful for them to cope with their child’s disorder. Parents receive information; therefore, the group does not serve as group psychotherapy or self-help for parents. Instead, facilitators inform parents how the group serves as a vehicle for the transmission of information. Facilitators conduct the majority of the group through presentations with handouts (Holtkamp et al., 2005).
The psychoeducational groups provide parents with detailed information about anorexia and bulimia (Holtkamp et al., 2005). Information presented includes the physiological and psychological consequences of semi-starvation and the vicious cycles of binging and purging. Holtkamp et al. (2005) explain that facilitators describe the core symptoms of both anorexia and bulimia as well as the physical, psychological, and cognitive consequences of each. Holtkamp et al. highlight how the facilitators stress “that the irrational fears surrounding weight gain cannot be countered by rational argument or reduced by psychotherapeutic interventions in the short term” (p. 384). Furthermore, facilitators advise parents not to enter into such discussions with their children, and if they do, to break them off as quickly as possible (Holtkamp et al., 2005).

Group facilitators summarize the etiology of anorexia and bulimia. Holtkamp et al. (2005) mention that explaining to parents the course of their child’s illness serves to increase the parents’ empathy for the distressing emotions of their child. Additionally, facilitators describe the interactions among biological, genetic, individual, sociocultural, and family factors (Holtkamp et al.). Facilitators also stress to parents that no casual link remains which proves that family factors contribute to the onset of anorexia or bulimia, although the disorder causes many negative changes in the family (Holtkamp et al., 2005).

Throughout the psychoeducation of the Aachen program, facilitators reassure parents that they represent a valuable resource in the treatment process. Therapists, parents, and adolescents construct a clear division of responsibilities and discuss the indications for inpatient treatment (Holtkamp et al., 2005). Holtkamp et al. (2005) explain that nutritional scientists present the basic principles of a balanced diet. They describe the components of nutritional rehabilitation, “including special diets, meal plans, model meals, cooking and eating in a group, family breakfast, and practice in self-responsible eating in a wide variety of situations” (Holtkamp et al.,
Nutritional scientists use practical examples of nutrition counseling from both inpatient and outpatient settings and discuss with parents typical problems of patients with eating disorders (Holtkamp et al., 2005).

Another component of the Aachen Program consists of patients writing a letter addressed to their eating disorders (Holtkamp et al., 2005). Holtkamp et al. (2005) explain how many of these letters reveal how the eating disorder served as a symbol of power, self-esteem, and pride. Parents acquire insight from these letters through realizing the “advantage their daughters gain from the eating disorder and why they often fear to gain weight or to get better” (Holtkamp et al., p. 386). Facilitators discuss strategies for relapse and answer parents’ questions about how to deal with problematic situations after their child completes treatment. Facilitators recommend to parents not to take responsibility for ensuring adequate energy intake or for preventing binge eating and vomiting by their child (Holtkamp et al., 2005).

The goal of the Aachen program remains to provide parents with relevant information during an early treatment phase (Holtkamp et al., 2005). According to Holtkamp et al. (2005), this could essentially “help minimize conflicts between patients, parents, and therapists, which are common in the treatment of eating disorders” (p. 388). One major benefit of the Aachen program compared to other traditional family therapy settings remains that individual parents involved in the psychoeducational group find the spotlight much less intense (Holtkamp et al., 2005). These therapy-oriented parent groups also offer a network of helping relationships where the parents can obtain guidance, support, and advice from other parents. Studies reveal that group psychoeducation involving patients and their parents prove as effective as family therapy with regard to eating disorder-specific or general psychopathology, weight gain, or length of inpatient treatment. Additionally, research reveals that group psychoeducation for parents of
adolescents with eating disorders may represent a useful and economic component in the treatment of eating disorders (Holtkamp et al., 2005).

**Multifamily therapy group.** A multifamily therapy group comprises another effective treatment method used to treat any of the eating disorders. Families involved in this type of treatment meet on an outpatient basis. Typically the adolescents involved in multifamily therapy previously completed an inpatient program (Dare & Eisler, 2000). Similar to the concepts of the Aachen program’s psychoeducational format, the multifamily therapy group offers a psychoeducational approach to eating disorders which helps families and patients to experience a sense of universality and cohesiveness (Tantillo, 2006). This group, which aims to help patients suffering from both anorexia and bulimia nervosa, primarily meets with participants on an outpatient basis (Dare & Eisler, 2000). Although Dare and Eisler (2000) explain that most of the patients previously completed an inpatient program. Dare and Eisler highlight research which suggests a multifamily therapy group elicits very positive responses from patients and their families.

Multifamily therapy groups maintain an extensive history of experimentation. While initially established as part of an inpatient psychiatric treatment, multifamily therapy groups expanded to accommodate a wide range of mental and medical illnesses and client populations (Dare & Eisler, 2000). Tantillo (2006) claims the group’s “main healing power is assumed to come from its large and diverse therapeutic social network, comprising individuals of different ages, classes, ethnicities, and life experiences” (p. 82). Dare and Eisler (2000) state a major emphasis in the psychoeducational multifamily therapy treatment approach involves supporting families in rediscovering a belief in their own ability to help their children overcome their problems.
Dare and Eisler (2000) explain that a general timeline for a multifamily therapy group program consists of about 24 weeks. Eisler (2005) states that “family members trying to cope with an eating disorder in their midst will often say that they feel as if time had come to a standstill and that all of their lives seem to revolve around the eating disorder” (p. 114). Research reveals that multifamily therapy group treatment may have positive effects in terms of decreasing high expressed emotion in families of patients with eating disorders. In addition, this treatment format improves family functioning and eating disorder symptoms showing a decrease in rates of family distress and high emotional overinvolvement (Tantillo, 2006).

Therapists facilitating the multifamily therapy group lead families and patients to experience mutual relationships with one another and empower the parents to help the patients disconnect from their eating disorder (Tantillo, 2006). According to Tantillo (2006), the multifamily therapy group model stresses the “importance of promoting mutual relationships in recovery and on understanding the role of disconnections (from the self and others) in the etiology and maintenance of eating disorders” (p. 83). The optimal family therapy model for anorexia and bulimia nervosa remains unclear (Tantillo, 2006). Additionally, according to Tantillo (2006), no empirical evidence thus far exists that clearly supports any particular treatment approach for adult anorexic patients, “although some studies have shown that family therapy is more effective than individual psychodynamic or supportive therapy” (p. 84). Tantillo highlights studies of adults with bulimia nervosa which reveal that individual cognitive behavioral therapy proves superior to interpersonal therapy. Taking the previously stated research into consideration, a multifamily therapy group model of treatment integrating best practices such as cognitive behavioral therapy, motivational, interpersonal/relational, and family
systems approaches serves as a good alternative treatment for patients with eating disorders (Tantillo, 2006).

Families who completed a multifamily therapy group responded favorably to this form of treatment (Dare & Eisler, 2000). Dare and Eisler (2000) report high levels of families’ enthusiasm and mention families feel grateful for the chance to compare their experience with other families. Additionally, Dare and Eisler report feeling surprised at the extent to which the adolescents supported each other about the struggles they went through. This sharing seems to give the patients an outsider perspective, as the adolescents can offer assurance to each other about their body image and self-concept (Dare & Eisler, 2000). A sense of mutual empathy and empowerment within the diverse therapeutic network of the multifamily therapy group motivates patients and families to persevere together on the path of recovery (Tantillo, 2006).

**Siblings’ Support and Role in Family Treatment**

Family therapy sessions offer a powerful tool in the recovery from an eating disorder. Family members often benefit greatly from family therapy sessions (“Family Therapy and Eating Disorders,” n.d.). All types of family therapy attempt to foster growth in the family and strengthen existing family ties (“Family Therapy and Eating Disorders,” n.d.). While parents of adolescents most commonly attend family meetings, siblings have the opportunity to play an important role in promoting patients’ progression towards recovery as well (Eisler, 2005).

Research on family systems with patients with eating disorders reveals that siblings commonly feel resentment or anger towards their suffering sibling for causing conflict within the family and between the parents (Eisler, 2005). Eisler (2005) explains how an eating disorder eventually begins to dominate family life. When this happens, families may find it increasingly difficult to attend to other needs within the family. The individual with the eating disorder may
require more of the parents’ time and attention while siblings may find themselves lacking the amount of support they need (Eisler, 2005). Therapists encourage siblings to attend and engage in the majority of family sessions. Siblings can offer emotional support to their loved one which proves pertinent and effective for an individual struggling with an eating disorder (Rhodes et al., 2009). Whitney and Eisler (2005) highlight studies indicating that siblings may play an important role in promoting patients’ progression towards recovery.

Researchers for a multifamily therapy group believe it may be most beneficial to hold separate family sessions with parents and the patient and with siblings and the patient (Dare & Eisler, 2000). Dare and Eisler (2000) explain that this would ensure siblings would be invited to come to family sessions while not required to attend every family meeting, as they found it difficult to hold the attention of the siblings. Dare and Eisler highlight a constant need for the families to think about the process of adolescent change and the importance of supporting offspring to lead the lives that they want to live, with siblings especially crucial to this discussion. An essential aim during family treatment remains to establish and reinforce a strong parental alliance around refeeding and caring for their offspring while also attempting to align the patient with the sibling subsystem (Krautter & Lock, 2004).

Support for Caregivers of a Loved One with an Eating Disorder

In many cases, individuals with eating disorders cannot recognize a need for help in themselves. It takes a strong, caring individual to reach out and help these individuals (“Family and Friends Offer Essential Support,” n.d., para 1). Parents, siblings, and close friends play a significant role in guiding and supporting their loved ones battling an eating disorder (“Family and Friends Offer Essential Support,” n.d., para 1). As a result of their support, many caregivers experience high levels of distress due to the difficulties in their caregiving role (Sepulveda et al.,
The most common areas of difficulty associated with caregiving include nutrition, dysregulated behavior, guilt, and social isolation (Sepulveda et al., 2008).

Researchers recently developed a scale to measure the specific caregiving burden of both anorexia and bulimia nervosa called the Eating Disorders Symptom Impact Scale. The 24-item scale includes four factors to assess the impact of eating disorder symptoms on family members: nutrition, guilt, dysregulated behavior, and social isolation (Sepulveda et al., 2008). Sepulveda et al. explain how caregiver burden includes physical, emotional, and social problems associated with caregiving. As a result, the Eating Disorders Symptom Impact Scale proves as a great value to highlight carers’ needs and to monitor the effectiveness of family based interventions (Sepulveda et al., 2008).

Interestingly, Sepulveda et al. (2008) report that the carers of people with bulimia nervosa experienced higher levels of general and specific caregiving difficulties than those with anorexia nervosa. Researchers also found that carers whose offspring were living away from home experienced lower levels of dysregulated behavior and less specific difficulties with the illness. Ideas offered to help alleviate some of the caregivers’ stress include psychoeducation, group support, strategies aimed at increasing social connections for carers, and teaching behavioral techniques (Sepulveda et al., 2008). Additionally, the National Eating Disorders website offers an abundance of resources for loved ones on how to be supportive of someone with an eating disorder. They recommend caregivers be patient and nonjudgmental, ask what they can do to help, have compassion when the person brings up painful issues, and to suggest professional help in a gentle way and even offer to go along (“How to be Supportive,” n.d.).
Males and Eating Disorders

While women more commonly develop eating disorders than males, recent studies reveal a growing number of cases in men (“The Numbers Count,” 2011, p. 3). Some studies reveal that men with eating disorders tend to have more passive-aggressive personality styles and experience negative reactions to their bodies from their peers while growing up (“Males and Eating Disorders,” n.d., para. 5). Anorexic males also tend to exhibit more dependent and avoidant personalities (“Males and Eating Disorders,” n.d., para. 5). An increased focus on body shape, size, and physical appearance in our culture likely contributes to increased numbers of eating disorders in males (“Males and Eating Disorders,” n.d., para. 2).

Unfortunately many controlled treatment studies exclude males from participation (Keel & Haedt, 2008). Keel and Haedt (2008) point out that some evidence exists that “the male-to-female ratio may be higher in children” (p. 57) than in adults. However, the lower overall rate of eating disorders in males makes it difficult to recruit adequate numbers to establish gender differences in treatment effectively. Additionally, since eating disorder interventions predominantly utilize females to design and test, it remains unclear whether these treatments would prove useful in treating boys with eating disorders (Keel & Haedt, 2008).

Adlerian Perspective on Family Therapy for Adolescents with Eating Disorders

Research on the Adlerian perspective for the treatment of eating disorders discusses the work of Milton Erickson. Erickson believed the family portrayed a strong influence in the development and maintenance of eating disorders (Bliss & Klein, 1990). Bliss and Klein (1990) highlight how family functioning provided indicators in the development of maladaptive behavioral patterns in eating pathology. Additionally, Bliss and Klein reference two studies which posit a relationship between early recollections of subjects and manifestations of eating
disorders. These studies revealed the life-style dynamics of subjects with anorexia nervosa reflected in their early recollections (Bliss & Klein, 1990).

Adlerian psychology views the person as a whole and looks at all aspects of an individual, including social functioning, work and school, family functioning, self-esteem, and spirituality (“Theravive,” n.d.). Adlerians believe viewing all aspects of the person makes up the five life tasks: work, friendship, love, self, and spirit (Sweeney, 2009). Sweeney (2009) explains that these life tasks generally develop between 6 and 8 years of age and remain unexamined and unchanged under normal life circumstances. Unsuccessful coping with basic life tasks suggests an individual may feel discouraged. In a healthy person, all life tasks interact for the well-being or detriment of the individual (Sweeney, 2009). Thus, an unhealthy person, discouraged with life and any area of the life tasks, seeks to find fulfillment in unhealthy means.

Adlerian treatment for eating disorders focuses on healing the underlying issues behind the eating disorder and the purpose it seems to serve (“Theravive,” n.d.). Adler believed that people constantly strive to meet some real or fictional goal in life; therefore, “the theory is teleological or goal-directed” (“Theravive,” n.d.). Bliss and Klein (1990) explain how the individual moves throughout the lifespan toward a goal of perfection. An individual’s movement toward a goal often focuses on overcoming a felt position of inferiority. In a child’s process of overcoming, he or she seeks a place of significance and a sense of belonging in the family and may choose to move toward a goal on the useful or useless side of life (Bliss & Klein, 1990).

Adlerian treatment recognizes that people with eating disorders often have mistaken perceptions, which can lead to destructive behaviors (“Theravive,” n.d.). The goal of Adlerian treatment techniques focuses on redirecting and reframing these mistaken beliefs (“Theravive,” n.d.). Bliss and Klein (1990) highlight how an eating disorder exemplifies an external
expression toward the useless side of life. An example of the external expression of useless striving may result in the surfacing of unconsciously motivated somatic symptoms, which eating disorders exemplify (Bliss & Klein, 1990).

A well known eating disorder treatment center located in Canada focuses on an Adlerian perspective in treating individuals with eating disorders (“Theravive,” n.d.). The founders of this treatment center, two Adlerian psychotherapists, believe that “by clearing and healing the blocks that may have accumulated due to pain, struggle, fears, negative thoughts, anxieties, or unrealistic expectations, people are able to rediscover their authentic selves, have self love, fully express themselves, manifest their dreams – and find their heart’s path” (“Theravive,” n.d.). The therapists utilize traditional talk therapy as well as guided imagery, art therapy, psychodrama, and body-oriented therapy (“Theravive,” n.d.). They aim to assist their clients in reaching deeper levels of awareness to help them understand how the eating disorder functioned in their life and what they need to do to develop healthier strategies (“Theravive,” n.d.).

Opinions on the Etiology of Eating Disorders

Studies investigating the opinions of professionals regarding various aspects of eating disorders remain limited (Erguner-Tekinalp & Gillespie, 2010). Erguner-Tekinalp and Gillespie (2010) report that only one study includes professionals’ opinions regarding the etiology of eating disorders. Erguner-Tekinalp and Gillespie highlight such a study which seeks to understand the professional opinions of mental health providers from Turkey and the United States concerning the etiology of eating disorders and their conceptualizations of the disorder. Erguner-Tekinalp and Gillespie state that “eating disorders have been understood as related to biological, developmental, individual, and sociocultural factors” (p. 69). Many issues may contribute to eating disorders that vary by culture, and cross-cultural examinations describe the
effects of Western influences on the development of eating disorders as mixed and contradictory (Erguner-Tekinalp & Gillespie, 2010).

Some evidence exists that certain cultural values may reduce the incidence of eating disorders. Erguner-Tekinalp and Gillespie (2010) point out that cultural attitudes in Belize, “where body size was thought to be a natural condition determined by one’s family heritage and over which there was little control, seem to protect women from disordered eating” (p. 69). In Turkey, some research shows the prevalence of eating disorders as lower than in the United States, but concern exists that increased Westernization may bring an increase in these figures. For example, the prevalence of eating disorders among college students in Turkey remains similar to that among college students in other countries (Erguner-Tekinalp & Gillespie, 2010). Erguner-Tekinalp and Gillespie point out that this increase of prevalence of eating disorders among college students may relate to a number of factors, including exposure to Western ideals, generational effects, high achievement orientation, greater stress levels, or higher socio-economic status.

Ample evidence suggests that the prevalence of disordered eating remains at least as common in some non-Western countries as in Western countries. Researchers propose it may prove possible that a rapid social change rather than Westernization leads to the higher rates of disordered eating (Erguner-Tekinalp & Gillespie, 2010). Erguner-Tekinalp and Gillespie (2010) report that rapid social change may lead to women’s need to express their personal conflict about changing their roles and identities, or that disordered eating in general may suffice as a culture-bound way to express any emotional distress. Erguner-Tekinalp and Gillespie gained an interest in comparing professional opinions on causes of eating disorders between different countries mainly due to the discrepancies in the nature and treatment of eating disorders geographically.
For example, more than 50 treatment centers specifically for eating disorders exist in the United States, excluding the services provided by the hospitals; in contrast Turkey has no clinics specializing in eating disorders, having these services provided mainly through hospitals (Erguner-Tekinalp & Gillespie, 2010).

The majority of the mental health professionals’ opinions emphasized the causes of eating disorders as behaviors and attitudes to cope with emotions resulting from irrational thoughts. The highest responses as likely factors leading to the development of eating disorders among the United States’ professionals include body dissatisfaction, perceived lack of control in one’s life, cultural ideal of thinness, media images of ideal thinness, low self-esteem, interpersonal insecurity, general cultural attitudes about food and weight, low self-esteem, obsessive thoughts, and perfectionism (Erguner-Tekinalp & Gillespie, 2010). Erguner-Tekinalp and Gillespie (2010) report the highest responses from the professionals from Turkey as body dissatisfaction, media images of ideal thinness, cultural ideal of thinness, peer influence, drive for thinness, high parental expectations, low self-esteem, interoceptive deficits, emotional avoidance, and negative mood.

Erguner-Tekinalp and Gillespie (2010) mention that the respondents from Turkey emphasized the immediate environmental influences on an individual: influences such as family, school, and peer groups relate to the microsystem. On the other hand, the respondents from the United States emphasized the larger cultural context: influences such as media and cultural influences make up the macrosystem. Eating disorders in Turkey do not commonly exist as part of daily conversations. On the other hand, the media gives considerable attention to eating disorders in the United States. Overall, body dissatisfaction, cultural ideal of thinness, and media
images of ideal thinness resulted as the leading causes of eating disorders by participants from both Turkey and the United States (Erguner-Tekinalp & Gillespie, 2010).

One study conducted by researchers in Spain on a sample of 2,862 girls ages 12 to 21 supports the role of mass media influences and parental marital status in the onset of eating disorders (Martinez-Gonzalez, Gual, Lahortiga, Alonso, Irala-Esteves, & Cervera, 2003). The researchers also highlight that the “habit of eating alone should be considered as a warning sign of eating disorders” (Martinez-Gonzalez et al., 2003, p. 315). Martinez-Gonzalez et al. (2003) reference a previous study on adolescents of both genders which identified that dieting and psychiatric morbidity had strong associations with the onset of eating disorders. In addition, researchers believe some parental and cultural influences serve as risk factors for eating disorders. Martinez-Gonzales et al. assert that, to the best of their knowledge, only one previous prospective study assessed the association between media exposure and the development of abnormal eating behaviors. Therefore, the purpose of the study completed by Martinez-Gonzalez et al. remained to assess the association between the parental, mass media, sociodemographic, and psychological influences and eating disorders.

As part of their study, Martinez-Gonzalez et al. (2003) referenced that they did not find any association between the development of an eating disorder and the number of siblings, birth order, previous psychiatric disorders in the family, or recent familial stressful events. Martinez-Gonzalez et al. (2003) did find that the proportion of girls who developed an eating disorder remained higher among girls who reported their parents as separated, divorced, or widowed than among girls whose parents were married. With regard to the use of mass media, the researchers found no differences in the incidence of eating disorders according to the overall number of hours the girls watched television during a typical week. They did, however, find a statistically
significant association showing that the incidence of eating disorders increased with the time spent listening to radio programs (Martinez-Gonzalez et al., 2003). In addition, Martinez-Gonzalez et al. (2003) report that more frequently reading teen girls magazines, at least once a week, also correlated with a higher risk of developing an eating disorder.

Gonzalez et al. (2003) strongly advise that parents and educators use caution to avoid letting girls eat alone frequently, as this habit proves a likely environment where an eating disorder develops. A strong social support coming from a stable family proves to better foster the psychological health of the offspring. Martinez-Gonzalez et al. (2003) conclude that the habit of eating alone, a situation of divorce, separation, or widowing in parents, and a higher use of some mass media correlated with a greater risk of developing clinically defined eating disorders. Lower self-esteem remains common among the disadvantages to children after parental separation, and a low level of self-evaluation relates to a predictor of eating disorders. Additionally, single parent families could more likely lack the ability to educate girls regarding food habits and eating patterns because of the absence of one of the two parents during meals (Martinez-Gonzalez et al., 2003).

Martinez-Gonzalez et al. (2003) claim that sociocultural factors prove as likely causes for the increasing rates of eating disorders among adolescent girls. Among factors in the cultural environment, Martinez-Gonzalez et al. state that “the influence of mass media usually transmitting unrealistically thin ideals have been most frequently implicated” (p. 319). Little research exists which directly assess the association between the frequency or time spent reading, listening to, or watching mass media and the future incidence of eating disorders (Martinez-Gonzalez et al., 2003). Martinez-Gonzalez et al. remain confident that the influence of mass media poses a greater risk for developing an eating disorder. Martinez-Gonzalez et al. claim the
likely explanation that these media convey to young girls an exaggerated pressure to achieve thinness. Martinez-Gonzalez et al. point out an obvious consequence that the messages transmitted by images of actresses and models in printed media often do not represent realistic standards of body size.

Another study examined the relations of adolescents’ pressures from the media, their mothers, and their peers with the development of eating disorder symptomology (Peterson, Paulson, & Williams, 2007). Eating disorders most commonly begin during adolescence, rather than in childhood or adulthood; therefore, Peterson et al. (2007) studied 333 male and female adolescents in grades 10-12 from a suburban area of the Midwestern United States. Previous research indicates that adolescents, particularly girls, experience the greatest drop in self-image at the time of school transmission. Many theorists agree that the physical, cognitive, and social changes of the adolescent developmental period make it a particularly troublesome time for individuals (Peterson et al., 2007). Additional research supports the contention that “adolescence is a time of particular vulnerability for the development of eating disorders” (Peterson et al., 2007, p. 629). Peterson et al. claim that the three factors most commonly found in the literature to relate to the development of eating disorders in adolescents include relationships with their mothers, their susceptibility to peer pressure, and their responses to media messages.

Research involving non-clinical populations of adolescent girls and adult women suggests that the prevalence of partial symptoms of disordered eating is higher than the full syndrome of eating disorders (Peterson et al., 2007). Peterson et al. (2007) mention a number of factors cited as contributing to the development of eating disorder behaviors: a disturbed mother daughter relationship, parents’ own dieting and worry about weight, parents’ encouragement of their children to lose weight, parental appraisals, teasing, and comments concerning weight and
shape of their children, and children’s disturbed eating attitudes and behaviors. Several studies reveal significant relations between adolescents’ perceived pressures from parents to lose weight and/or remain thin and body dissatisfaction. Individuals may internalize these pressures which puts them at an increased risk for the development of eating disorder symptomology (Peterson et al., 2007).

Research reveals that peers may have a significant influence on the development of eating disorders, especially during adolescence (Peterson et al., 2007). Peterson et al. (2007) mention that “both direct behaviors and comments from peers and perceived pressure to be thin from peers were related to difficulties with body image for adolescent boys and girls” (p. 630). Additionally, many believe that the mass media encourages an obsession with weight as those portrayed in it often resemble society’s ideal body weight and size, which most adolescents remain incapable of duplicating. Peterson et al. report that several studies demonstrate the negative influences on body image that result from viewing ultra-thin models in magazines and on television. Although most studies found that media influence poses a greater effect for girls than boys, studies prove body dissatisfaction in males decreases significantly when viewing advertisements with male models, especially images of muscular men (Peterson et al., 2007).

Peterson et al. (2007) believe that perceptions of pressure from the media may prove especially influential to the development of eating disorder symptomology. Peterson et al. highlight another study which revealed that “perceived pressure from the media is important to the development of eating disorder symptomology as an independent contributory risk factor” (p. 631). Peterson et al. mention another study which found that consistent cumulative messages from family, peers, and fashion magazines led to a strong drive for thinness in girls. Therefore,
Peterson et al. gather that pressure from multiple contexts would relate to higher levels of symptoms than would contexts individually.

Peterson et al. (2007) administered the Sociocultural Attitudes Towards Appearance Questionnaire (SATAQ) to their participants, an instrument designed to confirm the influence of a sociocultural factor in the development and maintenance of body image disturbance. Their findings provided support for the need to consider many aspects in an individual’s life in determining those factors that play a part in the development of eating disordered symptomology (Peterson et al., 2007). Correlations showed that students who perceived greater pressures across all three environmental contexts, the media, their mothers, and their peers, also reported more eating disorder symptomology, particularly with dieting, body dissatisfaction, and drive for thinness. Specifically, symptoms of bulimia also were higher in participants who experienced high pressures across multiple aspects of their lives (Peterson et al., 2007).

Girls in the study by Peterson et al. (2007) reported higher perceived pressures from the media to meet cultural ideals for physical beauty. Many researchers hypothesize that the media sends a stronger message to females than males regarding the importance of physical attractiveness. Furthermore, the media’s implicit and explicit message regards dieting as normal and a positive way to control weight, and frequent advertisements for weight loss using specific dieting programs, diet pills, and exercise equipment portray a positive message (Peterson et al., 2007). Peterson et al. report that girls appeared more susceptible to pressures from their mothers and from the media and that both related to lower body dissatisfaction; whereas, in boys, pressures from media related specifically to dieting behaviors.
Recommendations for Future Research

Advances in treatment for eating disorders in recent years demonstrate great success. Eisler (2005) reports that “we may have begun to acquire reasonable knowledge of which treatments work but we still know very little about how treatment works, what facilitates it and what prevents it from working” (p. 126). For example, researchers believe more systematic inquiry on the efficacy of family-based treatment for adolescent anorexia nervosa remains (Le Grange, 2006). Le Grange (2006) adds that he believes more work should continue to investigate efficacious treatments for anorexia nervosa in general.

Since family members caring for persons with an eating disorder often experience general distress, anxiety, and diminished quality of life, researchers hypothesize that reducing caregiver strains prove as detrimental to improving such outcomes (Le Grange et al., 2010). Le Grange et al. (2010) highlight that “attempts have been made to better understand both positive and stressful components of caregiving” (p. 3). Le Grange et al. further explain that limited knowledge remains about how to best understand and improve caregiver distress, especially when parents remain seriously ill. Literature for such parents remains considerably important to provide education about the illnesses in hopes of reducing levels of distress, negative care giving experiences, and guilt and shame (Le Grange et al., 2010).

An aspect of the psychoeducational multifamily therapy group researchers believe could use improvement deals with leaders focusing more of their efforts on the promotion of patient and family strengths and resilience (Tantillo, 2006). Tantillo (2006) expresses that training should include “reinforcement of how relational patterns that maintain eating disorder symptoms may have been present before the illness and/or developed in the face of the eating disorder and the strain it places on patients and families” (p. 99). With regards to the family meal program,
possible future developments could require that parents bring their own food to the unit and prepare it for a meal with the patient (Jaffa et al., 2002). Jaffa et al. (2002) explain this would serve as an intermediate step between eating their food at the center and their food at home. Another possible development with the family meal program entails outreach services which could enable therapists to enhance the program by providing support in the home setting (Jaffa et al., 2002). Eisler (2005) believes once we move the focus of family research away from questions of aetiology to questions of interaction between family function and treatment, or change in general, the gaps in our knowledge will become all too visible.

Additional research remains necessary on cross cultural comparisons of professionals, students, and lay people’s perception of the causes of eating. Future research calls for more diverse participants utilizing multimode data collection techniques. Erguner-Tekinalp and Gillespie (2010) suggest that differences in beliefs concerning the causes of eating disorders have tremendous effects on treatment of individuals with eating disorders. Therefore, it would also prove beneficial to explore whether treatment choices of mental health practitioners relate directly to their perception of the causes of the problem (Erguner-Tekinalp & Gillespie, 2010).

Future research remains necessary in discovering the many causes of eating disorders. While previous work examined the influences of either just mother or parents playing a role in the etiology of eating disorders, more must be known about the fathers’ roles in these behaviors. Also, since sociocultural pressures experienced by males may tend to encourage muscula-rity and fitness rather than thinness, measures of symptoms that may prove more common in boys should be reviewed more frequently. Research that explores the roles of multiple contexts on different eating disorder symptomology could help further the development of prevention and intervention
programs targeted more specifically to the behaviors common within each gender (Peterson et al., 2007).

**Summary, Conclusions, and Recommendations**

Eating disorders continue to emerge as a considerable risk to the psychological and physical health of adolescents. Eating disorders frequently progress to chronic illnesses that require multiple hospitalizations and long-term treatment (Sim, Sadowski, Whiteside, & Wells, 2004). Studies show an increase of eating disorders over the last 30-40 years (“About Eating Disorders,” n.d.). Researchers view anorexia and bulimia nervosa as life-threatening disorders (“Males and Eating Disorders, n.d., para. 7). They estimate the mortality rate among people with anorexia around 56 percent per year (“The Numbers Count,” 2011, p. 3). With approximately 8-11 million eating disorder sufferers across America, effective treatment methods come in high demand (“Males and Eating Disorders,” n.d., para. 1).

Past research focused on the role of the family in causing or contributing to the eating disorder (Le Grange et al., 2010). Family members often experience pain and strong emotions while feeling powerless to help their loved one suffering from an eating disorder (Engel et al., 2007). The majority of research conducted on the treatment of eating disorders stems from treatment for anorexia nervosa while the applicability of family therapy for bulimia nervosa received little attention. Thankfully, advances in research produced positive results proving the effectiveness of family treatment for bulimia nervosa as well. Since considerable overlap exists in symptomatology between anorexia and bulimia, much of the research targeted toward treating anorexia also proves applicable to treating bulimia (Le Grange, 2010).

Many techniques used for treating both anorexia and bulimia overlap and serve similar purposes. Mealtimes often represent a stressful event for families dealing with a loved one with
an eating disorder. Many families identified their need for practical guidance on how they can best assist a member with an eating disorder (Leichner et al., 2005). Therefore, Leichner et al. wrote a manual and created an accompanying video to provide more specific information and strategies for families and friends wishing to participate in meal support. Adlerian treatment for eating disorders focuses on healing the underlying issues behind the eating disorder and the purpose it seems to serve (“Theravive,” n.d.).

The National Eating Disorders web site offers an abundance of resources for loved ones on how to be supportive of someone with an eating disorder. They recommend caregivers be patient and nonjudgmental, ask what they can do to help, have compassion when the person brings up painful issues, and to suggest professional help in a gentle way and even offer to go along (“How to be Supportive,” n.d.). Since eating disorders affect a broad range of people including men, women, adolescents, and people from different socioeconomic and cultural backgrounds, numerous forms of therapy exist to suit the needs of any patient. (Additionally, since eating disorder criteria involve a vast array of dysfunctional eating or dieting behavior, an extreme need remains for experienced and successful treatments both for the individual and the family.)

Eating disorders include chronic conditions that lead to a decreased quality of life in personal, interpersonal, and financial realms (Peterson et al., 2007). It remains important to remember that the devastating effects of eating disorders cross gender lines and severely impact the health and well-being of both men and women (“Males and Eating Disorders,” n.d., para. 6). Researchers and professionals must continue to study and gain knowledge on the ever changing effective treatment interventions and techniques in order to assist in the healing and recovery
process of this growing epidemic. Every sufferer must know that hope and healing exists for them and remains attainable through help and support of loved ones and professionals.
References


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