Family Therapy for the Treatment of Eating Disorders

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Eating disorders have been prevalent all around the globe for hundreds of years. Currently, the American Psychiatric Association recognizes four disorders as falling under the category of an eating disorder in the DSM-5 (2013): Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), and Avoidant Restrictive Food Intake Disorder (ARFID). According to Hudson, Hiripi, Pope, and Kessler (2007), tens of millions of people in the United States suffer from an eating disorder at any given time. Furthermore, Smink, van Hoeken, and Hoek (2012) point out that eating disorders have an alarmingly high rate of death. As the years have gone by, many different techniques have emerged as ways of treating eating disorders. These techniques originate from various schools of thought (e.g., psychodynamic, behavioral, and cognitive behavioral), and allow for multiple techniques in which a therapist can treat a client suffering from an eating disorder. Of the different treatments available, one specific form of treatment stands out among the rest: family therapy. Family therapy has risen above all other therapies when it comes to eating disorders, and the evidence which supports it is vast. The goal of this paper is to analyze the literature pertaining to why, how, and for whom family therapy works best for the treatment of eating disorders.

Before examining each of the eating disorders and how family therapy is used for them, it is important to understand the basis for where these disorders come from and why family therapy is so effective. In a study conducted investigating the role of the parents on a child developing an eating disorder, the researchers found that negative attachment styles and bad family functioning can lead to eating disorders (Latzer, Hochdorf, Bachar and Canetti, 2002). On a more general note, the multidimensional model of eating disorders suggests that eating disorders are the result from interplay between the individual, family, and culture (Brytek-Matera, and Czepczor, 2017). The dual-pathway model of eating disorders is the combination of “the socio-cultural, dietary

and affect regulation aspects related to eating disorders" (pg. 3). Finally, the transdiagnostic model suggests that all eating disorders share common symptoms, and as a result, people who suffer from one specific eating disorder often segue into another one over the course of treatment (Fairburn, Cooper, and Shafran, 2003). A combination of these three models has led to the creation of a transtheoretical model of eating disorders (Brytek-Matera, and Czepczor, 2017). If the basis of eating disorders lay somewhere within the aforementioned models, then surely the family is an important factor to consider when dealing with people who have been diagnosed with eating disorders. Therefore, it makes sense that family therapy has become such a popular treatment for them.

The underlying principle beneath family therapy is that rather than the child or the child's behavior being the cause of the eating disorder, the cause lay within the structure and behavior of the child's family as a whole. What this means is that there are other factors which need to be addressed when dealing with a family. Le Grange, Hoste, Lock and Bryson suggest that parental warmth seems to be extremely prominent when it comes to the treatment outcome of Anorexia Nervosa (2011). Another factor in eating disorders which is pertinent is parental aggression. Sugar and Krueger (1995) conducted a study using a tool they created, the family aggression scale, to measure levels of covert and overt aggression in parents before and after treatment using systemic family therapy. They found that shifting a family's communication style to one of overt aggression created significant improvement in patients with AN. Furthermore, Pereira, Lock and Oggins (2006) suggest that just as other disorders need a good therapeutic alliance to be treated effectively, so too a good therapeutic alliance is of utmost importance to preventing further weight loss in a child diagnosed with AN. A good alliance will also help prevent parent dropout.

The first of the eating disorders to be discussed in this paper is Anorexia Nervosa. AN is a disorder that is most frequently diagnosed in women ages 14-25 (but can occur both earlier and later), and is characterized by "distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat" (American Psychiatric Association, 2013, pg. 1). In its main form, people who suffer from AN restrict their calorie intake and partake in behaviors that don't just preserve their chronic low body weight, but often increase their weight loss (Lock and Fitzpatrick, 2007). Medical and physical issues such as malnutrition and osteoporosis are what often lead people with AN to seek treatment (Rome and Ammerman, 2003). People with AN may also be experiencing cognitive distortions about what they should like and how their bodies should appear (Lock and Fitzpatrick, 2007). They often place so much emphasis on their body image that they don't realize their health is deteriorating.

Treatment for AN has historically been problematic. While disorders such as anxiety and depressive disorders often follow strict patterns and are more easily recognizable, AN can often go undetected for months. Although low weight and a lack of eating may be apparent to family members, they often will not say anything until it is 'too late' and the person has reached a life-threatening condition. Furthermore, if the person does not live with his/her parents, he/she can go an extremely long time without receiving help. Therefore, Walsh, Wheat, and Freund argue that the primary care physician (PCP) plays an important role in evaluating and detecting AN among patients (2000). The PCP's involvement in treatment is integral in making the decision of whether or not a patient needs to be hospitalized. Additionally, the PCP is able to keep updated records of the patient's weight and can evaluate if the patient is experiencing any issues related to weight loss or specific, maladaptive eating habits.

In 1987 Russell, Szmukler, Dare, and Eisler conducted the first ever controlled trial of family therapy on patients diagnosed with AN and BN (1987). Their goal was to test the effectiveness of family therapy in comparison to individual therapy. The family therapy approach they used was developed by Dare and Eisler at the Maudsley hospital in London, and consisted of three therapeutic tasks which occurred during three explicit phases. The three tasks in order were gaining family cooperation, assessing the family structure by observing a family meal, and creating interventions to help the family change. The first phase focused on a family meal and asserting the parents' control in feeding their child. The second phase was focused on the child's maintaining a stable, healthy weight and returning the family to its normal routine. The third and final phase was focused on returning control of eating to the child and reintegrating the child into society. By using the Morgan and Russel scale to test the patients' levels of the disorder during treatment, they received results which showed that family therapy was superior to individual therapy in patients who had developed AN at younger age and if the disorder hadn't become chronic. However, for patients who were older (over age 18) and for whom the disorder had become chronic, individual therapy still seemed to be the best route to take for treatment. Unfortunately, the results of using family therapy for the patients with BN did not show any clear benefit over individual therapy.

A further advantage of using the Maudsley approach is that its benefits have been shown to remain consistent years after going through treatment. Eisler et al. conducted a five year follow up on patients who had undergone their treatment (1997). They concluded that although much time had passed, it was still possible to detect certain beneficial elements of the therapy that they had undergone. They further stated that even though AN has a natural course and some of the positives can be attributed to the factor of time, there were still other benefits present.

Although the Maudsley approach to family therapy was proven to be effective in the treatment of AN, it is not the only form of family therapy. Le Grange, Eisler, Dare, and Russell conducted a study which tested the effectiveness of conjoint family therapy and family counseling on patients diagnosed with AN by using the Morgan and Russel scale (1991). Conjoint family therapy was conducted with all family members present in the therapy room simultaneously, while family counseling was conducted with the parents and children separately. Their results concluded that both forms of therapy were effective forms of treatment when it came to weight gain in the anorectic child. Interestingly, there did not seem to be much of a difference between the effectiveness of the two treatments. Similar results were seen in a randomized controlled trial (RCT) done a few years later by Eisler et al. (2000). In the study they compared conjoint family therapy with separated family therapy, and found that the treatments were similarly beneficial and effective in treating AN. This once again suggests that much of the issues related to AN can be treated by systematically restructuring the family to work together towards the common goal of cooperation.

Another version of family therapy, behavioral family systems therapy (BFST), was compared against ego-oriented individual therapy (EOIT) by Robin, Siegel, and Moye (1994) to test the impact on families with a child diagnosed with AN. According to them, “BFST emphasized parental control over eating, cognitive restructuring, and problem-solving communication training” (pg. 1). The individuals were split into two groups and given their respective treatment. The study showed that BFST was more successful than EOIT. At a one-year follow-up they found that the patients who had received BFST were better off than those who received EOIT. This study also confirmed that structured therapies for AN have an impact on family relations, even when during therapy there is discord among the members of the family

and they do not see themselves as a single, cohesive unit. Robin et al. (1999) later conducted a comparable study pitting BFST against EOIT for AN and found similar results. However, this time they found that between 20% to 30% of patients did not fully gain their weight back, and 40% to 50% of the patients were unable to reach the 50th percentile of the Body Mass Index by the time a one-year follow-up was conducted. They also found that even though both therapies worked, BFST produced a faster return to health.

Family therapy can be expensive. Therefore, a more cost-effective version of family therapy, family group psychoeducation (FGP) was created by Geist, Heinmaa, Stephens, Davis, and Katzman (2000). In FGP multiple families (up to seven) undergo therapy at the same time with up to two therapists. They found that FGP was an effective treatment for severely ill patients with AN provided that they hadn't been enduring the disorder for more than a few months. Although FGP wasn't *more* effective than the usual family therapy, it is still important to acknowledge FGP as being an effective, cheaper solution to family therapy.

Although success had clearly been found in running RCTs of family therapy using the Maudsley approach on patients with AN, how far could these results be taken into the actual clinical practice? Early on, Walter Vandereycken called for the creation of a "science-practitioner" model for the treatment of AN and BN (1987, pg. 1-2). Vandereycken argued that too often family therapists place emphasis on unimportant factors while undermining some of the important factors. Some therapists are too overeager and call for extra rigorous treatment, while others take a more 'backseat' approach in the naïve hope that the disorder will simply disappear after it runs its course. In order for the Maudsley approach to become more widespread, it was important that it become a manualized form of therapy that [theoretically] any trained clinical psychologist could treat patients with. Therefore, James Lock and Daniel Le Grange set out to do

exactly that. In 2001 they released their manual based on the Maudsley approach and they called the treatment Family Based Treatment (FBT). Soon after releasing the manual, Lock and Le Grange discussed the process they took in creating and testing the manual in an article that they published (2001). To create FBT they had to "review the current descriptions which existed for AN, consult with other clinicians who were trained in the Maudsley approach, develop a narrative structure that fit the model of treatment, test out the manual, and train others how to use it" (pg. 3).

How well does FBT work? Lock et al. (2010) conducted a large RCT of 121 patients with AN comparing the effects of FBT and adolescent-focused individual therapy (AFT). They found that at the end of treatment both groups of patients showed similar levels of remission. However, upon checking in with the patients six to twelve months later, they found that those who underwent FBT were doing better than those who underwent AFT. A meta-analysis was done comparing the efficacy of FBT and individual therapy (Couturier, Kimber and Szatmari, 2013). Similar to Lock et al.'s study, the meta-analysis showed near equal levels of remission after treatment, but at the six to twelve-month mark, FBT was found to be more effective. In addition, a dissemination study conducted in a Canadian clinic demonstrated that FBT can be just as effective in a clinical environment as a treatment facility (Couturier, Isserlin, and Lock, 2010). This study also confirmed that therapists generally have high levels of fidelity to the manual during all phases of FBT.

As good as FBT seems to be, there are certainly problems which exist. For instance, in a study conducted with 40 therapists, 95% of them said that they would like to receive further training in practicing FBT (Couturier et al., 2013). Furthermore, the therapists expressed frustration with their own abilities to create and monitor their patients' diet. Many of the

therapists had trouble keeping track of their patients' weight. Another issue was the monetary factor. Most of the therapists did/could not pay for a dietician to consult with. There was also the issue of space (for the family meal and activities) and the need for a specific environment in which families could feel comfortable. On that note, modified versions of FBT have been created to address some of the concerns voiced in the aforementioned study. Lock, Couturier, and Agras created a more cost effective, shorter version of FBT (2005). The results showed that their shorter version was effective and useful in treating patients who had only been suffering from AN for a short duration. Another cost-effective solution could be the use of enhanced cognitive behavioral therapy (CBT-E) for the treatment of *all* eating disorders. Grave, Calugi, Doll and Fairburn found CBT-E to be most effective for adults and late-adolescents with eating disorders (2013). The mean BMI of their patients after a 60-week follow-up was increased dramatically to the 26.9th percentile, and over one third of the patients had reached within 95% of their ideal/appropriate weight.

Another unfortunate issue with FBT is that it may not be effective in the long run if it doesn't show quick, beneficial results. A study conducted by Doyle, Le Grange, Loeb, Doyle and Crosby showed that if you don't start gaining weight earlier on in FBT (usually by the fourth session), then you are unlikely to remit upon the end of the treatment (2010). All of these issues with FBT may lead one to ask, if there is a chance that FBT might not be effective, is it even worth the cost, time and effort that it takes? Some therapists have recently gone so far to say that because there have not been any replication studies conducted separately from model developers, allegiance effects could account for much of the "apparent superiority of family therapy" (Jewell, Blessitt, Stewart, Simic and Eisler, 2016, pg. 14).

The next of the eating disorders to be discussed in this paper is Bulimia Nervosa. BN is diagnosed at similar rates in both men and women (with women being slightly higher) and is characterized by "frequent episodes of binge eating followed by inappropriate behaviors such as self-induced vomiting to avoid weight gain" (American Psychiatric Association, 2013, pg. 2). There are two defining features of the binge-eating behavior in BN. The first is that the bingeing is associated with feelings of loss of control, and the second is that the binge has to take place over a short duration. The main difference between AN and BN is that people with BN are usually either at a normal weight or overweight (Lock and Fitzpatrick, 2007). Rome and Ammerman write that allowing BN to go on for too long without treatment can lead to problems such as death, dehydration, cardiac arrythmias, and more (2003).

What is it that causes BN? As with AN, it is very likely that it is a combination of factors, and the aforementioned transtheoretical approach could be extremely helpful in our understanding of its origins. However, Annette Kluck presented her theory that BN could be caused by comments that the child's parents made to him/her which increased the child's level of body image dissatisfaction (2010). Her correlational study found that families which focused on appearances and families that constantly made comments about weight and size seemed to increase the symptoms for BN in their child. As she herself puts it, "a little over 20% of the variance in bulimic symptomology was explained by an appearance-focused family culture" (pg. 12).

How does one treat BN? Treatment for BN has primarily been individual therapy, with cognitive behavioral therapy being the therapy of choice. However, despite the initial disappointing findings for using family therapy in the treatment of BN, much progress has been made since then. Le Grange, Lock and Dymek have written an article in which they describe the

steps necessary to manualize FBT for the treatment of BN (2003). They believed that based off the fact that AN with the binge/purge subtype had previously been successfully treated using FBT, BN – a disorder that contains bingeing/purging – might also benefit from FBT. As with AN, their manualized version for BN would involve three phases. Phase one would be focused on regulating the adolescent's eating and purging. The next step of phase one would be for the parents to be absolved of the worry that they caused the disorder in their child. Once the child is comfortable with everything that occurred in phase one, the child would then move on to phase two. Phase two would focus on negotiating with the child and then returning control over eating to him/her. It would also be the time that other family issues that had been put to the side would be brought back to the surface to deal with. The final phase begins when all binge/purge behaviors have ceased. In this phase the child would establish a new relationship with the parent that doesn't just revolve around his/her eating disorder.

Not many RCTs exist for testing the effectiveness of FBT for the treatment of BN. One of them was conducted by Le Grange, Crosby, Rathouz, and Leventhal (2007). In their study they compared FBT and supportive psychotherapy for the treatment of BN. Their results showed a clear statistical and clinical advantage in using FBT. However, despite the lessening of the bulimic symptoms in the patients who received FBT, they acknowledged that the positive results could have been caused either by the very fact that there was family involvement, or by the focus on the eating behavior itself. What can be gained from this study is that there is a strong possibility that FBT works for BN.

Unfortunately, to this day there are only three RCTs that have been done to test FBT for adolescent BN (Rienecke, 2017). What is clear at this point is that we need more research on FBT for BN to determine how effective it truly is. As for Binge-Eating Disorder and Avoidant

Restrictive Food Intake Disorder, there is extremely little research on how to treat these disorders. Currently, the treatments for them depend on the therapist, but are usually cognitive behavioral therapy and/or family therapy. Rienecke continues in her article to describe the need to adapt FBT for all of the four eating disorders. She writes that there are going to be times when the standard FBT will not work even for AN. Not all families can be treated with FBT, and it is important that researchers try to come up with new ways and adaptations of current treatments to be successful in treating eating disorders in the future.

Similarly, Dimitropoulos et al. (2015) called for a new manual to be created for FBT to treat eating disorders. They specifically discussed the need to adapt FBT for treating people between the ages of 16 and 21 (the transition age youth). Likewise, Ringer and Crittenden (2007) called for a modified version of family therapy to be created for women between the ages of 18 and 45 who have been diagnosed with AN/BN. There is no doubt that as the years go on eating disorders will constantly keep on evolving. Therefore, it is necessary to revise and adapt the way family therapy is currently being practiced.

Throughout most of this paper I have been discussing eating disorders for women. But where is all the research on eating disorders in men? Strother, Lemberg, Stanford and Turberville investigated this exact question, and came up with a possible reason why people are not studying eating disorders in men anywhere close to the same capacity that they are studying them in women (2012). They write that men are “under-diagnosed, undertreated, and misunderstood” (pg. 2). The reason they provide is that men don’t often engage in the same common behaviors that women display in AN and BN. Instead of vomiting or restricting calories, Men may exercise rigorously to maintain their body shape and weight. Also, men oftentimes do not even realize that they have an eating disorder. The number of variables in male eating disorders are much

higher than in female eating disorders, and this makes men very difficult to study. Similarly, Limbers, Cohen and Gray (2018) write that significantly more research needs to be done on men with eating disorders. Not only by studying men through RCTs, but also by creating new forms of measurements specifically for men with eating disorders.

Nearly all of the research since the late 20th century has shown that there are significant benefits to using family therapy for the treatment of eating disorders. The manualized version of the Maudsley approach, FBT, has proven to be a successful tool in clinical practice. Despite all the shortcomings associated with FBT, it still stands as the treatment of choice for AN, and it is quickly moving towards the same direction for BN, BED, and ARFID. Over the years, different forms of family therapy have emerged that fix some of the shortcomings of FBT. Research on male eating disorders has not been promising, however, people are becoming more aware of this gaping hole in our knowledge. Adaptations of existing family therapies are underway, and researchers are hopeful that these adaptations can be used to continuously improve upon the treatment of eating disorders. Who knows? Maybe one day family therapy will not just become the therapy of choice for all eating disorders, but even for other disorders as well.

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