Updated evidence-based recommendations for family interventions for eating disorders

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Abstract
This paper is a brief review of empirical support for family therapy of eating disorders. It highlights the most important recommendations that emerge from recent research. While key theoretical concepts in the field were developed in the 1970s, clinical trial-based practice guidelines for treating patients suffering from eating disorders have been developed in recent years. Inspired by traditional family therapy, nutrition-focused family therapy has proven effective, especially in treating younger non-chronic patients with eating disorders.

Keywords: Eating disorders, family therapy, evidence-based review, clinical trials.

Introduction
In the past 30 years, important theoretical concepts linking families with eating disorders have been published, along with various models for family therapy. While the theoretical concepts drew largely on clinical experience, there was very little research backing to substantiate them (1,2). Given the high morbidity and mortality rates, detecting effective family interventions for eating disorders is critical. The purpose of this paper is to summarize the main findings of recent literature on treatment and their contribution to effective family treatment for eating disorders.

Background
For decades, researchers have agreed that the most likely cause of eating disorders is the family (3). This belief has deep historical roots. Physicians in the nineteenth century recommended that anorexic girls be separated from their families to ensure proper
nutrition: “The patients should be fed at regular intervals and surrounded by persons who would have moral control of them, relatives and friends being generally the worst attendants” (1,4). Assumptions about the family as the source of eating disorders abounded, and these gave rise to models for family intervention (1).

Although the contribution of the family to the disorders is the focus of some research, we have yet to find definitive evidence for their causes. Interestingly, while recent research has tended to disclaim family background as the source, these same studies point to the importance of family involvement in advancing treatment (5).

The family approach that has been the subject of the most comprehensive research is based heavily on the systematic-structural model. Other models, such as the strategic-systemic and cognitive-behavioral, have also had their influence (6). The systematic-structural model, as its name suggests, focuses on family structure and relationship issues, such as hierarchies, problematic alliances and coalitions, communication disturbances, inappropriate emotional involvement, high levels of parental criticism of children, and conflicts that perpetuate symptoms. According to this model, the issue of control is central and becomes the focus for family intervention. In cases of eating disorders, the issue of control is addressed with regard to food, whether from the point of view of the patient’s food intake or the family’s helplessness in the face of the patient’s illness (7). In utilizing systematic-structural family therapy, the therapist reinforces inter-generational limits by re-enacting family situations in the treatment room. In these situations, the therapist assists the reorganization of family interactions. The therapist blocks or encourages interaction patterns in keeping with the level of intimacy or privacy best suited to the developmental needs of the family members, thereby preventing them from reverting to their symptomatic behavior (7).

In 1978, Minuchin et al (8) published the results of an uncontrolled follow-up study of systemic-structural family therapy employed in the cases of 53 adolescent girls suffering from anorexia for less than a year who had requested therapy for the first time. Some had been hospitalized for a short time, but most were treated as outpatients for six months on average. Results were measured at the completion of therapy and also at follow-ups at intervals of 18 months to seven years. Approximately 80% of the patients sampled were monitored for at least two years. The criteria for measuring the impact of the therapy were linked to the patients’ physical condition and psychosocial functioning (within the family, in society and at school) (8). Surprisingly, family functioning was not measured. The reported rate of success using the systematic-structural approach was remarkably high: 86%. The 1978 study (8) was followed by additional uncontrolled research measuring the results of this therapy with non-chronic, anorexic adolescent girls, and the results indicated that the underlying therapeutic model was satisfactory (9,10). There was some criticism of the methodology used in these follow-up studies, particularly the lack of control groups and the absence of other types of intervention for purposes of comparison (11).

In their research, Minuchin et al (12) set out to measure the influence of therapy on what they described as a typical family structure for eating disorders – a “psycho-somatic family” characterized by enmeshment, over-protectiveness, rigidity, and an inability for conflict resolution. In this type of family, the ailing child plays a central role in the pattern of conflict avoidance, and communication takes place most often in the form of body language. The psychosomatic (or "anorexogenic") family, conclude the researchers, not only fuels the disorder but creates it (12). Studies that followed did not find evidence of these characteristics in the families of anorexic or bulimic children (13-15). Many studies over the last two decades conducted on families in which one member suffers from an eating disorder describe family risk factors and characteristics. However, the correlation between these factors and instances of eating disorders is not necessarily causative, as the pioneers of the systemic-structural approach argued (3,16).

The main limitation of the systemic-structural model was its focus on etiology rather than on an understanding how families organize themselves to deal with a life-threatening problem. However, once symptoms appear, the model can help the therapist understand how these symptoms are perpetuated by the family. Treatment providers, therefore, can implement family resources in order to advance
healing and coping processes through development assignments appropriate to the patient’s age (2,17).

Today, family therapists who treat eating disorders are faced with questions that demand evidence-based responses:

• Of the various therapeutic approaches involving the family, which is the most effective for treating eating disorders?
• Which basic family therapy techniques have proven effective, specifically in relation to eating disorders?
• Which family members should be included in family therapy, and when is it advisable to alter the composition of family members participating in treatment?
• Which aspects of the eating disorder should be included in family intervention?
• What are the phases of family intervention for treatment of eating disorders?
• Are different types of intervention necessary for various types of eating disorders (anorexia, bulimia, bingeing, and ED-NOS), age groups (young girls, adolescents, adults), stages of the illness, and degree of severity (acute, chronic, fluctuating)?

It appears that evidence-based answers exist only for some of these questions.

Evidence-based family therapy

Like other fields of health care, family therapy, and family therapy for eating disorders in particular, needs to employ treatment that is grounded in empirical evidence. This demand comes from those who finance mental health services and from those who provide the services – the therapists – both of whom seek proven methods of treatment for specific problems (18-20). Evidence-based therapy is administered according to systematically applied, written guidelines. This type of manual-based therapy is a relatively new approach and differs from clinical, experience-based treatment, which reflects the conventional opinions of therapists and those considered experts in the field, without the backing of research evidence (21).

Many clinicians have expressed their unease with treatment manuals and are suspicious of guidelines for family therapy. In recent years, however, research-based recommendations were published in the U.S. and Britain, where there were also attempts to formulate a handbook for family intervention that could be used universally to examine the degree of treatment effectiveness, compare results, and formulate recommendations for improving treatment methods (22,23).

Evidence-based family therapy for anorexia nervosa

Family intervention trials for anorexia nervosa have employed various forms of family therapy. Two studies focused on adults, five exclusively on adolescents, and one on adults and adolescent patients together (24). Family interventions that have proved effective in treating anorexia are found to include the following components (6,25):

• An effort to mobilize the adolescent and her parents for therapy, with the objective of building, strengthening, and maintaining motivation for treatment and eliminating the risk of drop-out. (Therapy drop-out rates are reported to reach 50%, a particularly worrisome figure given the life-threatening nature of the disorder).
• Psycho-educational intervention that addresses the characteristics of the disorder and its risks.
• Prioritization of weight rehabilitation and regular follow-up by a dietician.
• A shift in focus from nutrition to issues related to appropriate adolescent development (increased independence, greater distance from family members, etc.) with the objective of identifying factors that reinforce symptomatic behavior in the adolescent girl.
• An effort to prevent a relapse after improvement has been achieved.

Most of the family interventions found to be effective took place on an outpatient basis. They
continued for a maximum of 15 months and 18 sessions.

The first controlled study of eating disorders, published in 1987, compared the results of treatment for anorexic and bulimic patients who, after inpatient weight restoration, were randomly referred to one of two methods of outpatient treatment. One group was treated through family therapy, while the other received what was defined as individual, supportive, “non-specific” intervention. While the family therapy relied to some extent on Minuchin’s model, it parted company with this approach by encouraging parents to help in re-feeding their adolescent children until weight restoration was achieved. General adolescent and family issues were deferred until the eating disorder behavior was under control. The emphasis in the therapy was on the need for the parents to cooperate with and support each other and to remain firm and consistent in their responses to their child's symptoms.

A follow-up a year later found family therapy to be more effective than individual therapy for relatively young patients, under the age of 19, who had been ill for a relatively short period of less than three years. For older patients, individual treatment tended to be more effective with regard to weight rehabilitation, but for the majority of patients studied this improvement later ceased (26). A subsequent follow-up study five years later showed that therapeutic achievements were maintained and that family therapy had proven to achieve better results than supportive individual treatment for the defined population of non-chronic younger girls (27).

In another study, published in 1991, anorexic patients were randomly assigned to one of four types of treatment: hospitalization, outpatient family therapy, outpatient group therapy, or follow-up with no additional treatment. The family intervention worked to establish appropriate limits, block the tendency toward excess intervention and invasiveness by the family, and encourage problem-solving while taking into account the desire to avoid conflict in the family. A one-year follow-up showed that the family intervention was as effective as the other interventions with regard to weight and psychological, sexual, and socio-economic functioning. It was also more effective than follow-up with no additional treatment (28). A two-year follow-up study in 1994 indicated that the achievements of the family therapy were maintained over time (29).

Another study, in 1994, assessed treatment of adolescents suffering from anorexia nervosa. Two types of randomly assigned intervention were compared: one group received system-behavioral family therapy and the other ego-oriented individual therapy. The family therapy promoted communication skills, problem-solving skills, and cognitive change for distorted beliefs and conceptions within the family. It also addressed familial processes, such as inter-generational coalitions, that hamper communication. The family therapist encouraged the parents to work as a team and to take responsibility for instituting the menu they were given for their child. When the adolescent reached the target weight, control of nutrition was gradually returned to her. At this stage, the family therapy focused on reinforcing the adolescent’s autonomy and improving communication patterns in the family.

In the second group, the adolescents underwent individual treatment that aimed to reinforce ego strengths and clarify the latent dynamic that hindered proper nutrition. The parents of the treated adolescents were seen periodically by the therapist, without their daughters.

The results indicated similar improvement for the two types of intervention with regard to nutrition, depression level, and family relationships. Family therapy proved more effective than individual treatment, both at the end of the treatment and at a one-year follow-up, with regard to weight rehabilitation and the date of resumption of the menstrual cycle (30).

A decade later, a similarly designed study showed the same trend. The characteristics of the sample were only slightly different with regard to depression rates, duration of the disorder, and duration of the therapy (31).

In the year 2000, a study on treatment of anorexia nervosa compared two randomly assigned types of family intervention. The first was conducted through separate sessions with parents and the ailing adolescent (separated family therapy). The sessions with parents focused on mobilizing the resources needed to overcome their feeling of powerlessness and developing mechanisms for coping with the symptomatic behavior of their daughter. At the same
time, the therapist conducted sessions with the adolescent alone. In the second form of intervention, the parents and the adolescent sat together (conjoint family therapy). The frequency and length of the sessions were similar in both interventions. The duration for both was about a year, and approximately 25 sessions were conducted.

A comparison of the results of both interventions after a year revealed no significant differences with regard to their shared therapeutic goals of achieving normal weight and preventing relapse and rehospitalization. In cases where the adolescent and parents met the therapist separately, slightly more psychological improvement was recorded for the adolescent. In a follow-up study two years after the treatment ended, it was found that the family members who participated in the separated family therapy reported a higher level of satisfaction with their current relations (fewer power struggles, accusations and quarrels). Another important finding was that families characterized by a high level of parental criticism (especially on the part of the mother) toward the adolescent at the beginning of the therapy had a more favorable treatment outcome when the parents and adolescent were seen separately (32,33).

Follow-up at the end of five years showed that the improvement achieved in both types of treatment sessions was maintained: for 75% of the patients significant improvement was observed, for 15% the improvement was moderate, and the remaining 10% showed poor results (32).

The results of the comparison between the two family therapy groups (separated and conjoint) are especially meaningful for family therapists, and it is therefore worth taking a closer look at some of the key features of these interventions (32):

- The therapist clarified to the parents at the start of treatment that the family is not the source of the disorder but the best resource for its effective treatment.
- The therapist provided detailed information to both the parents and the patient about physical and psychological consequences of malnourishment.
- The therapist explained to both the parents and the patient the compulsive nature of anorexic behaviors that tend to govern the lives of adolescents and their families.
- To the parents, the therapist stressed the need for parental involvement in nutritional rehabilitation, without resorting to criticism of the adolescent. Consistency, firmness, and determination in promoting nutritional rehabilitation, it was emphasized, should not be translated as insults and accusations.
- The therapist encouraged the parents to support their daughter to help her take back control as soon as possible.
- The therapist supported and encouraged the parents to maintain a positive marital relationship, in part to enable the adolescent to realize that her parents have lives together beyond the mutual care of their children.

In both the separate and conjoint sessions, the initial focus was on parental control of nutritional rehabilitation. At a later stage, as the patient’s physical condition improved, the focus shifted gradually to family relationship and adolescent development issues. The guiding therapeutic principle was to help the family separate undesirable eating habits and patterns of interaction related to nutrition from psychological problems within the family.

These two forms of family therapy express concern about the dangers of malnutrition and urge the parents to act firmly to rehabilitate their daughter’s eating habits while, on the other hand, they encourage the adolescent to claim her right to privacy, autonomy, and personal aspirations. Anorexia was described by the family therapist as an internal enemy that deludes the young girl into thinking that the condition is her real voice, when in fact the anorexia makes her insignificant and rules her through the psychology of hunger.

In the session with parents only, the therapist discussed strategies to achieve a change in eating habits without intervening directly in the parent-child interaction. The therapist took a supportive and empathic position toward the parents, while encouraging them to avoid criticizing their daughter. Issues surrounding the marital relationship were not raised unless doing so would reinforce the parental coalition as a means of facilitating the key objective of the nutritional rehabilitation.
During the first phase of treatment, nutrition at home should be the parents’ responsibility, since they are charged with buying, preparing, and serving the food according to a predetermined menu. The parents, as opposed to the adolescent, are responsible for their own nutrition and that of the entire family. If the patient seeks autonomy, it should not be in the area of nutrition; she should be given other, age-appropriate ways of achieving it (34).

Meals should be planned in advance according to the instructions provided by the treatment staff, and they should end after a predetermined length of time. It appears that there is no benefit to preparing or ordering special foods for the adolescent (34).

The individual sessions with the adolescent had a counseling-supportive style aimed to prepare her for discussions about further sensitive topics. One component of all sessions with adolescents was the influence of the anorexic symptoms on family relationships. The sessions with the younger adolescents were most effective when they focused on subjects directly connected to the eating problem. With older adolescents, the therapeutic discussions were effective when they widened to address how the girls themselves felt about their social life, family life and more.

To summarize, the purpose of the study was to compare two types of family therapy. The findings reinforce the conclusions of previous research showing that encouragement of direct parental intervention in regulating nutrition brought about symptomatic improvement and positive psychological change in their daughters (26,28,30,32,35). Moreover, it appears that parents are interested in taking on this role for the sake of their children. A study published in 2004, showed that 88% of the participating parents related positively to the role given to them in regulating their daughter’s nutrition (36).

Treatments that encourage parents to play an active role in addressing their daughter’s eating habits seem the most effective. Methods that instruct parents to refrain from attempting to influence their daughter’s eating habits, at the same time encouraging them to understand her condition were found to be less effective (30). The absence of parental intervention in regulating nutrition was also found to delay recovery (26,27).

The encouraging results for family therapy for adolescents were not duplicated for older patients (2,26,27,37). While the parents of adolescents should be responsible for nutritional rehabilitation, the preferred method for adult patients is to distance the eating problem as quickly as possible from its dominant role in family relationships (38). There is little convincing data regarding the effectiveness of family interventions with adult patients (over age 19) who suffer from anorexia nervosa (11). In addition, family therapy has been found to be less effective than other methods for patients with chronic or late-onset eating disorders (37).

A controlled study published in 2001 compared family therapy with individual therapy for adult patients suffering from anorexia nervosa after hospitalization. In one-year and five-year follow-ups, it was found that, compared with a control group that did not undergo therapy, both family and individual intervention correlated with a greater improvement in weight. Although there was no significant difference between the types of treatment, there was a slight advantage to individual treatment with regard to psychological adaptation (37).

Evidence-based family therapy for bulimia nervosa

While there is evidence of the effectiveness of family therapy for anorexia nervosa, systematic research on family therapy for bulimia nervosa is nearly non-existent (11-39). This gap may stem from the fact that bulimia was categorized diagnostically only in recent decades and therefore a useful body of knowledge about its therapeutic dynamics has yet to be accumulated.

Some researchers have suggested reassessing the diagnostic distinction between bulimia nervosa and anorexia nervosa. Both disorders may exhibit binging and vomiting, and it appears that the single outstanding difference between them is the severity of the weight loss. At any rate, it has been found that family intervention is effective for both restrictive anorexics and anorexics with bulimic symptoms (27).

In 1995, a controlled study that examined the application of family intervention for eight adolescent girls suffering from bulimia nervosa showed a
significant lessening of bulimic symptoms, which was maintained in the follow-up a year after completion of treatment (40).

A recent randomized controlled trial conducted for adolescents with bulimia nervosa showed a clinical and statistical advantage for family-based treatment over supportive individual psychotherapy at post-treatment and at a six-month follow-up. Family therapy also appears to be a more efficient means for achieving early symptomatic relief. This form of treatment is impartial about the cause of the disorder but assumes that normal adolescent development is negatively affected by the condition. The model shares many characteristics with the previously existing family-based treatment model applied for anorexia (41). The usual treatment for bulimia proceeds through three phases: sessions are weekly in phase 1 (2-3 months), every second week in phase 2, and monthly in phase 3. In the first phase, the therapist tells the family about the physical and psychological risks of the disorder. Although this often arouses anxiety in the parents, the ultimate objective is to involve them in the course of the treatment, foster awareness of their daughter’s condition and increase their motivation for treatment. At the same time, the therapist makes it explicitly clear to the parents that there is no place for blaming or criticizing the patient, and that there is no proof that any blame for the disorder lies with the family. The treatment aims at empowering parents to disrupt binge eating, purging, restrictive dieting, and any other pathological weight control behaviors. It also aims to separate the adolescent herself from her disordered behaviors in order to promote parental action and lessen adolescent resistance to their assistance. Once the adolescent’s disordered eating habits and related behaviors begin to wane, phase 2 begins, and parents gradually pass control over eating issues back to the adolescent. Phase 3 focuses on the ways the family can help counter the effects bulimia on adolescent developmental processes (42).

Despite the use of this procedure, there is still some doubt as to whether the treatment model initially designed for anorexic patients is also suitable for bulimic patients, who sometimes exhibit different traits: greater independence, rebelliousness, higher risk for sexual promiscuity, and abuse of addictive substances (26).

In another recent study, 85 adolescents with bulimia nervosa or ED-NOS were randomly assigned to family therapy (at least 13 sessions, plus two individual sessions, over six months) or to therapist-supported, self-guided, manual-based, cognitive-behavioral therapy (15 sessions over six months). The findings suggest that while adolescents with bulimia nervosa can benefit from family therapy, their conditions improved more dramatically with cognitive-behavioral therapy (43).

Practice guidelines for the treatment of patients with eating disorders

To date, three comprehensive guidelines for the treatment of eating disorders have been published. The first, "Practice guideline for the treatment of patients with eating disorders", was published in 1993 by the American Psychiatric Association and based on the most current research findings at the time (44). A third revised edition was published in 2006 (45). The chapter on family therapy for anorexia nervosa recommends that therapists mobilize family support for the benefit of the patient and her treatment. Family intervention has been found to be especially effective for adolescents under the age of 19 years, who are living at home with their families and whose disorder was diagnosed less than three years earlier. The publication recommends therapy when family problems perpetuate and reinforce eating disorder symptoms.

For bulimic patients, family therapy should be considered whenever possible, particularly for adolescent patients living with their families and adult patients with problematic family relationships. Similarly, adult patients are likely to benefit from intervention by their partners.

In 2004, a clinical guideline was published by the National Institute for Clinical Excellence (NICE) in England, in cooperation with the Association of Psychologists and Union of Psychiatrists (46). The document strongly promotes family intervention that directly addresses eating disorders, and it recommends their use for children and adolescents with anorexia nervosa. In a chapter specifically devoted to family intervention, therapists are advised to include a psycho-educational component in their
work – basic information about the disorder that includes its cause(s), factors that perpetuate and reinforce it, proven ways of helping the patient, and the anticipated course of the disorder and results of the treatment. The chapter also recommends providing the patient and her family with information about the risks accompanying the disorder, warning signs of possible physical dangers, and concrete steps that can be taken to reduce risk.

The degree of family intervention recommended, according to the 2004 guideline, depends on a number of factors, including the age of the patient the relevant developmental issues, and the severity and risk level of the illness. In addition, it was recommended that the therapist update the families of minors about any unusual findings, worsening of the condition, or possible danger to the patient.

For minors suffering from anorexia nervosa, the guideline recommends guided family intervention at the onset of treatment. The immediate objective is to involve the family in the therapy. While anorexic patients often lack insight into their condition and their level of motivation for therapy is low, parents are sometimes skeptical about categorizing anorexia as an emotional disorder, and they are not certain of the need for any sort of psychological counseling. The therapist, therefore, must first try to build a good working relationship with the family.

For patients suffering from bulimia nervosa, the 2004 guideline recommends treatment that includes cognitive-behavioral therapy, anti-depressants, and family intervention, as appropriate. The guideline further suggests that parents and siblings of minors suffering from all types of eating disorders be routinely included in the treatment procedure. Intervention may consist of sharing information, counseling for behavioral management, and advice on facilitating communication. It is also recommended that parents be involved in meal planning for minors.

In 2004, a clinical practice guideline for the treatment of anorexia nervosa was published by the Royal Australian and New Zealand College of Psychiatrists. It notes that family therapy has been found to be a valuable component of treatment, particularly for children and adolescents. With regard to "schools" of family therapy, no specific family approach is superior to any other (47).

The 2001 "Treatment manual for anorexia nervosa" is the first published guideline for the family-based approach. Extending beyond traditional family therapy techniques, this model is geared specifically for intervention by families of patients suffering from anorexia nervosa (43). It was inspired by Minuchin and his colleagues and developed at Maudsley Hospital in London. The model has been widely adopted and implemented in treatment centers around the world.

The 2001 manual was designed to empower parents to disrupt the powerful behaviors maintaining their child's low weight. The model is impartial to the cause of the eating disorder and assumes that normal adolescent development is negatively affected by the disorder. The treatment aims to achieve behavioral change as soon as possible, again, without focusing on the reason for the occurrence of the disorder. It is conducted on an outpatient basis and includes 20-25 sessions of about one hour each, divided into three phases over the course of a year. Sessions are weekly in phase 1 (two-three months), every two weeks in phase 2 and monthly in phase 3.

At the beginning of the intervention, parents are given responsibility for their daughter's nutrition. With the support of the treatment staff, the parents give the girl the message that the food is a form of medication and that self-starvation is not an option. The parents are encouraged to find suitable ways of guiding their daughter toward a nutritional routine that will rehabilitate her physical condition. Though assisted by the staff, the parents must have a high degree of determination and persistence. The therapists free the parents from guilt over the appearance of the illness; it is portrayed as something that has taken over patient. This approach is reminiscent of what narrative family therapy calls "externalization," (48) which also helps parents refrain from blaming their child for the illness.

In the second phase, after attaining the desired weight, the adolescent gradually regains control of her nutrition. This is the time to deal with difficulties within the family.

In the third and final phase, the intervention focus shifts to problem-solving and critical adolescent development issues. It is best to discuss these issues only after the signs of anorexia recede, thereby opening the possibility of building family
relationships without the intervening factor of the eating disorder and all it entails. Family therapy is contraindicated for families with a history of violence and exploitation.

**Conclusions**

Family Therapy in the treatment of eating disorders has come a long way in the last three decades. Current evidence shows that family therapy is especially effective for non-chronic adolescents below the age of 19 who live at home with their families. Controlled studies of this population, especially for anorexia, have shown that family therapy is more effective than any other therapeutic format.

The findings accumulated in recent years indicate that family therapy at the beginning of intervention on nutrition issues has proven its effectiveness in treating eating disorders, especially with adolescents. While the treatment of adult patients may include family members and spouses as needed, the most effective approach has proven to be cognitive individual intervention.

Despite the progress in the field, further research is needed to establish a useful, evidence-based body of knowledge for family therapists who treat eating disorders.

**References**


