

Investigation of the Role of the Family in Anorexia Nervosa Treatment

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Abstract

Anorexia nervosa burdens individuals with an unyielding obsession with weight loss and food restriction, ultimately leading to extreme emaciation and even death (Kaye, Fudge, & Paulus, 2009). This disorder most often plagues adolescent females, with estimates of prevalence in 0.2% to 1% of adolescent girls (Mirsa et al, 2011). Current literature suggests family relationships and dynamics, rather than blaming individual family members, are essential in understanding and ultimately treating the disorder for adolescent girls. This paper will review the literature on family relationships and dynamics conducive to disordered eating among daughters, as well as examine the findings regarding supportive family environments. Additionally, this paper will evaluate the interplay of genetics and environment in the development of anorexia. Given the cited impact the family has on the etiology of anorexia, this paper will note the importance and strengths of family therapy for the treatment of a daughter's anorexia.

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Eating disorders, specifically anorexia nervosa among adolescent daughters, stem from a multitude of factors interacting with each other, such as biological, personality, cultural, and family factors (Lavee, Latzer, & Gal, 2009). The latter factor receives much attention from psychologists when implementing treatment, given that the both the etiology and maintenance of eating disorders with regards to pathological family systems remain as a focal point for research (Latzer, Hochdorg, Bachar, & Canetti, 2002). However, the family's role in eating disorders is different than previous assumptions. Eisler and Le Grange (2008) suggest that the mere idea of the family possessing a central role in eating disorders dates back to the late 19th century, yet the type of role has experienced a shift over time. Originally, the perception of the family's role was as an obstacle regarding treatment, causing the exclusion of parents and siblings from treatment. The 1960s introduced a shift in which Salvador Minuchin and colleagues suggested that families could play an integral role in the recovery of family members with eating disorders (Eisler & Le Grange, 2008). Investigating this familial role in assisting patient recovery remains as a necessity for eating disorder treatment.

Due to the shift regarding the family's function in eating disorders, the importance of and necessity for family therapy entered the scene. According to Lock and Le Grange (2005), family therapy exists as one of the most commonly recommended types of treatment, along with individual psychodynamic psychotherapy and cognitive-behavioral therapy. However, the latter two forms of therapy, as Fitzpatrick and Lock (2007) claim, are lacking in comparison to the observed effectiveness and consistency of family therapy. Because of this effectiveness, Lock and Le Grange (2005) make the bold claim that anorexia nervosa possesses the title of the model illness for family therapy.

Despite the influential role of the family in eating disorders, Latzer et al. (2010) assert that no amount of data sustains the idea that family members are causally related to eating disorders. Specifically, psychologists and researchers alike are adamant in their disapproval of any therapeutic model placing family members in the category of blame for the etiology of eating disorders (Latzer et al., 2010). Le Grange, Lock, Loeb, and Nicholls (2010) claim that theories of causation based on family members are both unsophisticated and flawed; they are similar to the discredited theories of the “schizophrenogenic” and “autistogenic” mother, which suggest that mothers are responsible for their children’s schizophrenia or autism. This rather unsophisticated and flawed perspective, popular in the 1970s, attributes the cause of anorexia to the “anorectic family” while considering the anorexic child to be a helpless victim (Minuchin, Rosman, & Baker, 1978).

While attributing the cause of anorexia solely to the family does not consider the many co-occurring factors of causation, disregarding the role of the family is just as detrimental to the etiology of the disorder. Blaming individual family members for an anorexic child’s behaviors is not the goal of family therapy; instead, identifying family dysfunction or possible relation to the anorexic child’s behavior remains the focal point. The exploration of family systems and family relationships conducive to eating disorders is central to a family therapist, all while attempting to reiterate that blaming individuals is not the goal. The “anorectic family” may be a bit too simplified and unsophisticated, but family therapists agree that certain family interactions are indeed conducive to disordered eating among adolescent family members, usually adolescent daughters. This paper focuses on adolescent daughters with anorexia nervosa given the 10:1 ratio of females to males experiencing this disorder (Baker, Maes, Lissner, Aggen, & Lichtenstein, 2009).

Family Dynamics Conducive to Eating Disorders

While individual family members do not cause the development of eating disorders, certain types of family interactions and relationships may aid in the shaping of eating disorders in adolescents – specifically daughters – in the family (Loth & Neumark-Sztainer, 2009). Discovering and understanding interactions among family members in which eating disordered daughters exist creates the ability to make predictions and employ effective treatment plans. Latzer et al. (2002) delineate some of the family variables that may suggest disordered eating habits of daughters: family social adjustment, roles, structure, communication, and coping styles with regard to conflicts.

Wade et al (2008) also suggest a positive correlation between anorexia nervosa in daughters and a predisposed family situation of perfectionism and high personal standards. Families with parents who expect often unrealistically high standards from their children, specifically daughters, may predispose the development of anorexia in adolescence. Wade et al (2008) specify that parental and self-criticism of unmet goals do not predispose adolescents to the development of anorexia; instead, the family's setting of these high standards in the first place influences anorexic behaviors.

Autonomy and Enmeshment

Latzer et al. (2002) present the idea that the inability to achieve separation and an autonomous lifestyle from parents, specifically the mother, commonly appears in the etiology of daughters with eating disorders. Michel and Willard (2003) are in accordance with such views regarding autonomy; they present an association between anorexia nervosa and difficulty with both separation from the family of origin and individuation. Such difficulties result from possible family atmospheres in which there is little to no emphasis for individuality, nor for

creating one's own identity. This lack of independence prompts adolescents to seek out ways in which to achieve their desired autonomy. A daughter who feels unable to distinguish herself from her family may use an eating disorder to aid in the establishment of her own separate identity and self-expression, given that her anorexia nervosa is unique to her and something in which she can feel comfort (Michel & Willard, 2003).

Families with difficulties in establishing independence for each member often experience enmeshment, the highest level of cohesion. Minuchin (1974) proposes enmeshment to be a product of diffuse – or too flexible – boundaries and overly intense emotional reactivity within the family, leading to the inhibition of each family member's individuality. Barber and Buehler (1996) describe this high cohesion level of enmeshment as hindering individuation among family members and further hampering psychosocial maturation. Eisler and Le Grange (2008) suggest that family structures expressing enmeshment, rigidity, and over-involvement – specifically in mother-daughter relationships – create vulnerability in daughters who, in turn, seek autonomy in unhealthy practices such as eating disorders. This intrusiveness by the mother creates strained mother-daughter relationships. Escaping from a mother's overbearing nature and over-involved tendencies placates daughters, allowing them to feel a sense of individuation and control. This sense of control is not otherwise felt, due to the mother's over-involvement within their relationship, which often leads to making decisions for her daughters and establishing all control. Through this exploration of enmeshment, rigidity, and over-involvement, Eisler and Le Grange (2008) emphasize the dysfunction of the mother-daughter relationship rather than the mother herself as conducive to her daughter's anorexia.

Weight-Related Conversation

Parents who make negative comments about weight – both their own and that of their family members – influence the weight-related opinions, attitudes, and behaviors of their children (Loth & Neumark-Sztainer, 2009). Because children learn from their parents and often adopt similar thought processes and beliefs, parents who associate weight and eating with negative connotations create an environment conducive to disordered eating. Growing up in a household of constant negative body talk often implants these negative thoughts in children's heads, simultaneously creating a lowered self-esteem and fear of weight gain.

Loth and Neumark-Sztainer (2009) specifically suggest that parents who make negative comments about their own body or weight, the bodies and weights of their children, and/or bodies and weights of other individuals expose children to detrimental perceptions about their own bodies. Becoming critical of their own bodies is an occurrence that manifests when parents are openly critical themselves. A father telling his daughter that she has put on a few pounds or a mother constantly belittling her own body creates an unhealthy, overly weight-conscious environment. According to Gowers and Shore (2001), while an overly weight-conscious environment consists of frequent direct comments by mothers, fathers, and siblings regarding weight, food, and dieting, a key component of this environment is that of blatant parental dissatisfaction with their child's – usually daughter's – weight.

Conflict Avoidance

Vidovic, Jures, Begovac, Mahnik, and Tocilj (2005) assert that conflict avoidance in families acts as a possible precursor, as well as maintainer, for eating disorders. Such conflict avoidance may not only exist with regards to eating behaviors, but the mere existence of such a family function may lead to the avoidance of acceptance, understanding, and treatment of anorexia nervosa. The fear of confronting a daughter's disordered eating exists due to the idea

that doing so may cause even more anxiety, then pushing her to eat even less as a response to the confrontation (Vidovic et al., 2005).

Additionally, Vidovic et al. (2005) posit that such conflict avoidance may exist because of unclear boundaries among family subsystems, specifically parent-child, and fragility in the system's balance. The fear of disrupting homeostasis, an innately desired sense of equilibrium, also stems from the desire for conflict avoidance. Confronting the anorexic behaviors of the daughter has the potential to dramatically change the family system in terms of the need for treatment and analysis of the family. Despite the grave necessity for treatment, families are reluctant to seek it because of the discomfort with making change in the system.

Parental Marital Relationships

Regarding subsystems, in addition to parent-child relationships receiving attention in research, the parental marital system also requires analysis. Lavee, Latzer, and Gal (2009) purport that daughters diagnosed with anorexia nervosa express conflict and distress within their parents' marriage, suggesting that such a subsystem influences their daughters' eating behaviors. Daughters witnessing a substantial amount of discord and lack of harmony between the mother and father experience dyadic issues with each parent, given that subsystems and boundaries experience misalignment due to marital conflict (Ringer and McKinsey, 2007). Perhaps as a subconscious attempt to shift the parents' focus from spousal fighting to something else, daughters may engage in disordered eating habits.

Lack of Psychoeducation

Given the complexity and challenging nature of anorexia nervosa, or any disordered eating for that matter, psychoeducation may provide families with the necessary information and skills to play the most effective role in treatment. According to Treasure et al. (2008), most

families report having inadequate information regarding eating disorders, in turn leading to insufficient skills in dealing with the illness. Because each family member attributes distinctive meanings and definitions to one's eating disorder, members respond differently to the illness. Idiosyncrasies of anorexia nervosa exist simply because each individual dealing with and experiencing the illness does so differently. Treasure et al. (2007) suggest the necessity for a clear conceptualization of the eating disorder, specifically to one's family system (p. 250). An important suggestion Treasure et al. (2007) make is that of attributing anorexia nervosa to a medical model, which decreases personal responsibility and blame. Fitzpatrick and Lock (2007) assert that doing so separates the pathology of the eating disorder from the daughter, which is essential in treatment.

In addition to aiding in the responses to the eating disorder among family members, Uehara, Kawashima, Goto, Tasaki, and Someya (2001) implement the idea that psychoeducation may facilitate lowering distress in the family, while promoting more positive interactions and communication in the family system. Psychoeducation places anorexia nervosa in a more structurally defined category, allowing families to similarly understand the disorder and use that understanding to have more effective treatment sessions, rather than continually stumbling over the specific meaning of the eating disorder to the family. Treasure et al. (2008) claim that such misunderstandings and misperceptions of the eating disorder may lead to the aforementioned family behaviors that aid in the development of the eating disorder in the first place, such as anxiety and conflict avoidance.

History of Family Illness

A study of the family tree with regards to which family members experience anxiety, compulsivity, rigidity, and/or eccentricity may aid in determining possible family influence,

according to Treasure et al. (2007). Discovering that the family system has members who possess diagnosed and undiagnosed eating issues is common when studying family histories in treatment sessions. Treasure et al. (2007) claim that on one end of the spectrum, other family members may express extreme dieting/restriction and bulimic or anorexic tendencies, and on the other end, may display episodes of binge eating and obesity.

Besides a family history of disordered eating, which is likely in cases of daughters with anorexia nervosa, other psychological disorders in the family may present themselves when family trees are held under the microscope of therapists and researchers. According to Treasure et al. (2007), many family systems in which daughters with eating disorders exist have first-degree relatives who are diagnosed with Obsessive Compulsive Personality Disorder and various anxiety traits. Such personality disorders and anxiety traits may lead to disordered thinking about eating, perhaps influencing daughters and sisters in the family system to obtain similar mentalities regarding food.

Genetic Risk Factors

An inspection of the family's history of illnesses may help identify a genetic component of eating disorder development. Le Grange et al. (2010) introduce mounting evidence that suggests that eating disorders have heritable and genetic influences. Such evidence is derived from molecular genetic studies, as well as family and twin studies. According to Baker et. al (2009), twin studies suggest heritability rates for anorexia nervosa between 22% and 76%. These percentages suggest that while environment still plays a vital role in the development of an eating disorder, genetic predisposition is also a factor.

Additionally, Bergen et. al (2003) investigate the role of serotonin and opioid activity in relation to anorexia nervosa in adolescent females. A decrease of serotonin activity, as in

depression and obsessive-compulsive disorder, correlates with anorexia nervosa (Kaye & Jimerson, 1997), further suggesting the co-morbidity of these three disorders. Serotonin activity is also related to weight regulation of the body and eating behaviors, suggesting a link to the development of eating disorders (Bulik, Landt, van Furth, & Sullivan, 2007). Like the aforementioned neurotransmitter serotonin, dopamine is also related to the symptoms of anorexia, given the relationship between dopamine activity and body image distortion, food repulsion, and weight loss (Bulik et al, 2007). A family history of abnormal serotonin and dopamine activity may therefore predict disordered eating patterns in adolescent family members.

Bergen et al (2003) explore the possibility of candidate genes associated with anorexia nervosa, finding that sequence variation at serotonin 1D (HTR1D) and delta opioid (OPRD1) correlates with individuals displaying DSM-IV anorexia nervosa diagnoses. Bergen et al's (2003) study presents novel information regarding the association between anorexia nervosa and sequence variation at HTR1D, while also noting that the second candidate gene associated with anorexia – OPRD1 – also correlates with alcohol and heroine dependency, suggesting an addictive and dependent quality of anorexic behavior.

Attachment

Three styles of attachment exist, according to Ringer and McKinsey (2007) – secure, ambivalent, and avoidant – and receive much attention in research regarding eating disorders and families. A common theme derived from such research, as Ringer and McKinsey (2007) claim, is that adolescent women with eating disorders, specifically anorexia nervosa, do not experience secure attachment within their family systems. With that being said, this lack of secure attachment stems from a family atmosphere in which the inability to offer a sense of security and

availability exists, as well as the perceived lack of ability to accommodate the daughter's needs (Latzer et al., 2002).

Results of the myriad studies conducted regarding attachment styles and eating disorders assert that ambivalent and avoidant attachment styles are likely predictors in disordered eating among daughters, with the latter attachment style being the most commonly represented style. An important study by Latzer et al. (2002) supports the relationship between family environment and attachment style in that discrepancies and variations in family environments disappeared when controlling for attachment styles. Such findings create the implication that without combined inspection of attachment styles, family functioning and environments themselves may not provide enough information regarding their influence on the development of eating disorders in families (Latzer et al., 2002).

The development of anorexia nervosa may redirect a daughter's concentration away from her lack of secure attachment toward the achievable goal of body image, according to Latzer et al. (2002). Being unable to control her attachment level is replaced with the ability to control her weight and appearance, acting as an internal sense of security that is not otherwise felt.

Family Dynamics Conducive to Support

While family interactions and dynamics may create an environment that supports the development and maintenance of an eating disorder, Eisler and Le Grange (2008) argue that the family itself is a resource for helping the daughter cope with and recovery from her eating disorder. Treating the family as a tool for recovery dislodges the incorrect idea that the family is to blame for such an illness, which lessens parental guilt. A family system that works to strengthen communication, lessen anxiety, and provide increased support to their daughter and each other strengthens the chance of a successful recovery.

Parental Support

According to Loth and Neumark-Sztainer (2009), researchers and therapists alike deem parental support as absolutely vital to the prevention and/or recovery of eating disorders. Showing such support exists in the form of expressing love and attention to their children, encouraging spending time together as a family, demonstrating unconditional love and acceptance, and supporting the identities and uniqueness of their children (Loth & Neumark-Sztainer, 2009). Being more present in the lives of their children is essential for parents dealing with a child, specifically a daughter, with anorexia nervosa. Brown and Geller (2006) suggest that mere physical presence and conveying love and concern for the daughter in the home and by attending therapy sessions is highly beneficial in the recovery process.

Supportive Food/Weight Environment

Because of the dominating presence of food in the family systems in which eating disorders exist, it is necessary to develop a positive and supportive environment in which food, weight, and body image are not attached to negative connotations. To do so, therapists encourage parents to have the least amount of food rules as possible, all while making an effort to eliminate any negative talk about food and eating in general (Loth & Neumark-Sztainer, 2009). Additionally, providing healthy food options to the family and encouraging positive mealtime experiences, such as family dinners with conversation and laughter or cooking together as a family, as Loth and Neumark-Sztainer (2009) suggest are likely to lead to a positive patient outcome.

Development of Psychoeducation

As previously mentioned, psychoeducation with regards to eating disorders, particularly anorexia nervosa, is essential in the recovery process, or even prevention in the first place.

Family members who understand the illness specific to their daughter or sister are able to have a more positive impact on the healing process as well as a better ability to make necessary changes in the home environment along the way. Loth and Neumark-Sztainer (2009) posit that parents and siblings with awareness of signs and symptoms of anorexia nervosa can predict greater chances of prevention, given that such an awareness may lead to an avoidance of conversations regarding body and weight in the home. Additionally, family members with knowledge of eating disorders and their warning signs may promote treatment more intensely and quickly than those who are unfamiliar with and uneducated regarding the illness.

Family Therapy

Treatment of a female adolescent's anorexia nervosa exists most effectively in the form of family therapy (Fitzpatrick & Lock, 2007). The therapist immediately addresses the importance of cooperation among all family members in order to achieve success in the realm of problem solving and recovery. Without the willing involvement of all family members, according to Michel and Willard (2003), the course of the eating disorder is likely to turn to a devastating one and recovery is unlikely.

Fitzpatrick and Lock (2007) introduce their particular treatment plan, beginning sessions with discussing how collaborative family therapy really is; while the therapist may be an expert in terms of the psychopathology of the eating disorder, the parents hold the title of expert in terms of their daughter. This open demonstration of the two-way nature of family therapy allows the parents to truly feel connected to the recovery process, as well as lessening the guilt they may feel for their daughter's illness. Such involvement of the parents, siblings, and daughter herself truly expresses the notion that the focus in therapy is not solely on the daughter with anorexia nervosa, but is on the family system as a whole (Michel & Willard, 2003).

Phase I

Fitzpatrick and Lock (2007) states that the first phase in family therapy for eating disorders aids in the discovery and employment of efficient techniques by the parents that can produce weight restoration in the child. The search for effective strategies begins with the therapist observing potential parental strengths in which weight restoration techniques can stem from; this creates a personalized system of strategies that caters specifically to the family's needs (Eisler & Le Grange, 2008). Because the first stage's primary focus is weight gain, other issues are not addressed until subsequent phases. Monitoring food intake and exercise is up to the parents at this point, according to Eisler and Le Grange (2008).

Phase II

Once steady weight gain, implemented and controlled by the parents, is observed in the daughter, Phase II of family-based therapy follows suit. In addition to weight restoration, the daughter must be eating with little to no resistance and an upbeat, positive mood exists in the family regarding treatment success (Eisler & Le Grange, 2008). The second phase, as explained by Eisler and Greange (2008), shifts the control of food intake from the parents back to the daughter, with hopes of the daughter continuing the healthy patterns in which the parents implemented in the first stage. This shift requires parents to step back and trust the daughter to make appropriate food-related decisions; not reverting to their enmeshed ways prior to treatment is important.

Phase III

Phase III can only begin when parental monitoring no longer exists in the realm of their daughter's eating and weight, both of which are in an acceptable and healthy range, as Fitzpatrick and Lock (2007) suggest. Eisler and Le Grange (2008) also insist that another

determinant of Phase III is the return of the daughter's menstrual cycle. Researchers and therapists alike assert that because the prior two phases focus more on the physical weight gain and eating of the daughter, the third phase can implement discussions of the development of the eating disorder, relationships among family members and peers, and specific concerns of the daughter, namely finding her? autonomy in the family. Fitzpatrick and Lock (2007) state that this third stage also introduces ways to change family boundaries and the possible need for the parents to make changes in their marital relationship.

Structural Family Therapy

A structural family therapist, like Minuchin (reference?), implements interventions that increase parental authority and confront inappropriate boundaries between subsystems, according to Lock and Le Grange (2005). Specifically, this school of therapy may incorporate a family meal in a therapy session, which allows the therapist to act as a coach for parents in terms of re-feeding, while also recognizing behaviors when food is involved and how to change the problematic ones (Lock & Le Grange, 2005). Problematic behaviors regarding food may manifest in forms of arranging food on the plate instead of eating it, becoming angry around mealtime, or parents demanding the daughter to eat.

Strategic Family Therapy

Strategic family therapists view the family in a positive light and do not demand an authoritarian role in sessions; they actually obtain a coaching position and only wish to adjust behaviors and relational issues that hinder the process of re-feeding, according to Lock and Le Grange (2005). Such therapists create a positive environment in sessions and encourage family members to convert their negative emotions regarding the eating disorder into positive ones.

This positive environment is also possible given that strategic family therapists do not view the family as pathological (Lock & Le Grange, 2005).

Medical Intervention

While family therapy remains a staple treatment procedure for anorexia nervosa among adolescent daughters, current studies suggest the implementation of medications for possible disease treatment in conjunction with family therapy. Powers and Bruty (2009) agree that while not a “first-line strategy” for anorexia treatment, pharmacotherapy is still an important avenue to explore. For example, antiepileptic drugs (AEDs), according to McElroy et al (2009), may extend beyond epilepsy treatment and also aid in the management of anorexia, given their effects on weight gain and appetite increase. Specific AEDs used for epilepsy in children and adults – pregabalin and valproate – may not only impact weight and appetite, but also provide mood stabilization, providing therapeutic effects as well (McElroy et al, 2009).

Current literature also posits the possible benefits of adding antidepressant medication to eating disorder treatment programs. Antidepressants – selective serotonin reuptake inhibitors (SSRIs), specifically – correlate with relapse prevention in anorexic patients involved in psychotherapy as well (Powers & Bruty, 2009). Given the co-morbidity of eating disorders and depression, implementation of SSRIs as an addition to a psychotherapeutic treatment plan for anorexia may further help with mood stabilization. Another possible addition to psychotherapy with the family is that of antipsychotic medications, specifically olanzapine. This particular medication, in accordance with therapeutic intervention, helps treat anorexic symptoms such as fear of weight gain, delusional body image, and obsessions (Powers & Bruty, 2009).

Conclusion

Based on the myriad research, family therapy receives much attention in the realm of eating disorders, often being labeled as the quintessential illness for such therapy. Family therapy suggests that certain family environments and relationships may be conducive to the development and maintenance of eating disorders, specifically anorexia nervosa. Such predictors for eating disorders may include enmeshed parents, lack of autonomy, conflict avoidance, negative body talk, unharmonious marital relationships, and lack of psychoeducation regarding the illness. Family therapists attempt to delve into the relationships and subsystems of families and discover effective strategies for recovery. Without the help of the family, the potential of recovery is slim; the family unit is essential in overcoming illnesses, especially those of disordered eating.

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