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ORIGINAL PAPER

Two Case Studies on Family Work with Eating Disorders and Body Image Issues

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Abstract This article highlights the need for clinicians who work with eating disorders and body image problems to address the deeper family issues underlying these symptoms. The authors propose an eclectic approach including family systems, structural and experiential family therapy theory as a guide. The paper begins with an overview of family therapy theories currently used in the treatment of eating disorders, and goes into greater detail about the three theories highlighted in the eclectic model proposed. The authors present two cases with actual case dialogue, demonstrating how they used this composite model. This article has both theoretical and practical implications for clinicians working in the field.

Keywords Body image · Eating disorders · Family therapy · Structural family therapy · Experiential family therapy · Family systems

Most therapists specializing in the treatment of eating disorders and body image issues are well educated in the practice of individual therapy and many are comfortable doing family work in conjunction with individual work, especially when treating adolescents who are still living under their parents' roofs. Yet many eating disorder/negative body image specialists have not devoted enough time nor education to studying complex family dynamics in the treatment of eating disorders and there is a dearth of research about this important topic (Dare and Eisler 2002; Lock 2011; Gurman and Kniskern 2014).

Since each family therapy model has its own strengths and limitations, the authors have proposed an eclectic approach as a guide for addressing the underlying issues common to eating disorder families. The paper begins with an overview of family therapy theories currently used in the treatment of eating disorders, and then goes into greater detail about family systems, structural and experiential family therapy theories—the three theories highlighted in the eclectic model proposed. The authors then present two cases with actual case dialogue, showcasing this composite model.

An Overview of Family Therapy Work with Eating Disorders

Currently, most family therapy work with eating disorders and body image issues includes a psychoeducational component. Therapists help family members understand how eating disorders develop, common methods of treatment and how they can behave supportively toward the family member with the eating disorder (Siegel et al. 2009). Another common technique in the treatment of adolescent eating disorders is the Maudsley method (Eddy et al. 2008; Treasure et al. 2007). Although there are many steps to this technique, a crucial one is that parents take full control over their child's food intake. When using the Maudsley approach, adolescents with eating disorders must be fully on board since lack of compliance results in consequences, sometimes even a hospital admission. This method hinges upon the ability to restore parental authority and has been supported to be effective in their research

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(Fairburn 2005; Lock et al. 2008; Lock 2011). Although the Maudsley method has been a valuable contribution to the field of eating disorders and family work, there are limitations. The research for this protocol is primarily focused on anorexia, leaving a need for more research on its applicability to other eating disorders. In addition, the focus of the Maudsley approach is on those who are living at home with their parents (Lock 2002; Lock and Le Grange 2015).

The need for parents to take charge was initially stressed by Salvador Minuchin, father of structural family therapy (Minuchin and Fishman 2009), a method that continues to be a foundation for family assessment and treatment. According to structural work, a problem in the family structure will result in symptoms that show up in family members; the main symptom bearer being the identified patient (IP). Structural family therapy continues to be widely used in helping troubled families (Nichols and Schwartz 2005; Nichols 2008) despite the fact that Minuchin's ideas have been criticized by feminist therapists and others. Luepnitz (1988) and Hare-Mustin (1988) argue that his ideas regarding family organization are based on gender norms from a bygone era and Minuchin's blunt and less sensitive style has been a point of contention (Nichols and Schwartz 2005). However, Minuchin has made changes since his early days in the field and despite criticisms, some research has shown structural work to be effective with anorexia (Minuchin et al. 1978; Campbell and Patterson 1995), and other behavioral disorders such as drug addiction and conduct disorder within families (Greif and Drechsler 1993; Szapocznik et al. 1989).

It is the authors' belief that structural theory provides an accessible model, which can be easily implemented. One of its main goals is to create a strong parental hierarchy, with parents in charge and working together to enforce appropriate boundaries (Nichols and Schwartz 2005, Nichols 2008); creating a springboard for healthy separation and differentiation for their adolescents. Within eating disorder families, family members are apt to become enmeshed (overly involved) and create coalitions (two family members teaming up against a third). According to Structural Family Therapy, the therapist challenges the old structure-that is, the structure that accommodates the eating disorder. Once challenged, the family realigns, with the IP resuming their proper role in the family and with parents on the same page.

Enactments are essential to structural work, and are also important in Sue Johnson's work in Emotionally Focused Couples Therapy (EFT) (Greenberg and Johnson 1988; Johnson and Johnson 2004). Enactments involve helping family members interact in a new, healthier way. The first part of creating an enactment involves the family therapist's assessing the problematic systemic dynamics. Then, the therapist uses tools to support and aid the family to relate in a healthier and more productive way (Minuchin and Fishman 2009; Jones 2010). For example, a mother may critique her daughter for being too fat, which results in the daughter's decreased self-esteem and tension within the mother/daughter dyad. In an enactment, the therapist helps the mother set boundaries with her own inner critic, while suggesting more positive ways she can interact with her daughter. The therapist's goal is to help the family interact in a more growth-inducing way so that practice in the session can become a reality at home.

Murray Bowen (1978) wrote about the potential dangers of passing down family patterns and/or individual pathology from one generation to the next. We often see intergenerational mother/daughter enmeshment or body image dissatisfaction in families with eating disorders. According to Bowen, once families are aware of this generational repetition, they can begin the process of change. Bowen also writes about family projection, that is, how a parent's fear and anxiety can be projected onto a child. For example, if a mother has dealt with her own challenges with body/weight, that anxiety and fear might be projected onto her daughter. There have not been research studies showing the effectiveness of Bowen's work (Nichols and Schwartz 2005, Nichols 2008). Yet, Bowen's initial writings on the significance of intergenerational repetitions and connections has been a significant contribution to family therapy, in general (Nichols and Schwartz 2005; Nichols 2008). McGoldrick and Carter went on to deepen Bowen's work by studying how families work, the family life cycle, and the effects of race, spirituality, ethnicity and gender (McGoldrick and Carter 1999). McGoldrick et al. (1999) emphasizes the use of genograms, which can reveal hidden family dynamics and help clinicians and families see these generational repetitions.

Experiential family therapy was first discussed in the 1970s by Virginia Satir and Carl Whitaker. The focus of experiential work is on feeling and communication (Nichols and Schwartz 2005; Nichols 2008). Sue Johnson's EFT work with couples has helped experiential work become popular today, as it is highly supported by research (Johnson and Johnson 2004; Greenman and Johnson 2013). Johnson stresses the importance of communication by helping people speak more clearly about their inner emotions and the stories that accompany them. The goal is to help family members hear one other with interest and compassion (Greenberg and Johnson 1988; Johnson and Johnson 2004).

Guy Diamond utilizes attachment and experiential theory in his work with depressed teens and their parents, stressing communication and expression of authentic

feelings to help the teen feel safer and more connected to the parent. Diamond's work is well researched in addressing depression in teens (Diamond et al. 2014). Jones (2010) stresses the importance of therapists as the "keeper of the conversation" between family members. He underscores the importance of helping family members communicate directly with one another and giving them tools/suggestions in continuing difficult conversations.

The authors posit that when applying experiential therapy to eating disorder family work, the therapist can create a more positive connection between the child and parent by getting family members to speak about their feelings in a clear and non-blaming way. According to Sue Johnson, secondary feelings (such as anger and frustration) act as a cover for primary feelings (sadness, fear, shame, and pain) and expression of primary feelings brings people together instead of pulling them apart. (Greenberg and Johnson 1988; Johnson and Johnson 2004). We find in families with eating disorders that primary feelings are often not discussed, making direct/clear communication challenging. In other cases, the expression of secondary feelings (for example, anger or frustration) may not be permitted, creating an atmosphere of repression, which can also contribute to an eating disorder.

Johnson's couples work can be applied to families with two main goals: helping the IP express feelings directly while parents listen with compassion *and* the parents expressing emotions to their child, while keeping Minuchin's hierarchy in mind. For example, the parent might express sadness or fear about the eating disorder, while maintaining boundaries around what they reveal. It is important that the child understand the parent as an emotional being, without feeling the need to take care of that parent. It is also helpful to point out destructive cycles in the family and how to break these cycles through more open and honest communication (Greenberg and Johnson 1988; Johnson and Johnson 2004).

The authors believe that a composite model; including some of the main tenets of family systems thinking, structural family therapy theory and experiential family therapy; can create an effective therapy model for change, although using all three theories is not necessary in every case. The authors also posit that if the family structure is supported while allowing for the expression of primary emotions, and for successful separation, IPs will be less likely to relapse since the reasons they developed these symptoms (in the first place) are adequately addressed.

No matter which family therapy technique one chooses, in working with adolescents the therapist must balance the need to protect the adolescent's privacy with the need to create a secure parent/child attachment (Barth 2003; Larcher 2005). Therefore, if the therapist is to do individual therapy by itself, the IP's issues may be addressed, but the family's conscious or unconscious pull to revert back into more enmeshed behavior may not be. The young woman's going off into the world—while keeping a connection to her parents -needs to be normalized by the therapist (Barth 2003; Lyons-Ruth 2003). This is why the authors believe that a family therapy approach is particularly helpful in cases involving a difficult separation.

In the following vignettes the authors outline two actual cases giving some background and history, and then presenting the dialogue and family therapy techniques used. Reflections on the case studies occur throughout the dialogue.

Case Vignette # 1

The first case highlights a modified structural approach which addresses multigenerational tendencies, while paving the way for clearer boundaries between family members and encouraging the strong parental hierarchical structure proposed by structural theorists. The therapist helps the daughter(s) create healthier boundaries with their parents, while also encouraging the mother to separate from her own mother. The end goal is for children to come and go and be accepted for whatever adult decisions they have made. The case involves a 16-year-old girl named Susan, her parents, Mr. and Mrs. Murphy, and her younger sister, Annie, age 13. The therapist was told Susan had social anxiety, along with anorexia and a negative body image.

It is important to note the family's background and ethnicity. Parents were both brought up in traditional Irish Catholic working class homes. Compliance was a family value, passed down intergenerationally and both Murphy parents were taught to never question their elders. Mrs. Murphy had never emotionally separated from her own mother (MGM), who was demanding and critical. No matter how hard Mrs. Murphy tried to placate her, MGM criticized Mrs. Murphy and saw Susan's eating disorder as a result of Mrs. Murphy's failings. Upon exploration of intergenerational patterns, it became apparent that Mrs. Murphy also had a negative body image. She referred to herself as "unattractive, unfeminine and boyish." Mrs. Murphy's poor sense of herself as a woman was also a contributing factor to Susan's eating disorder.

In the initial meeting with the Murphys, it became apparent that there was enmeshment between Susan and Mrs. Murphy. This enmeshment served many purposes for this family including: protecting Susan from having to face the world and protecting mom from separating from her own mother and facing marital closeness and intimacy.

The following excerpts highlight crucial aspects of the treatment:

In the below dialogue, a boundary was created by addressing the mother/daughter enmeshment, and encouraging Susan's separation while giving Mrs. Murphy the subtle message she should let go of Susan, rather than holding her close and projecting her own fears onto her daughter.

Therapist:	(Turning to Susan) "What is your name"?
Mrs. Murphy:	"Her name is Susan."
Therapist:	"I notice you answer for her. Is there any reason for that"?
Mrs. Murphy:	"She's very shy. She has social anxiety."
Therapist:	"So, I'm going to start out by asking you both if it's okay for Susan to answer for herself. What do you both think"?

After gathering some family history, and creating a genogram, the therapist hypothesizes that enmeshment is intergenerational and causes women in the family to become stunted and afraid. When women can't separate from their mothers, they are less available for the intimacy necessary for a healthy marriage. In the Murphy family it appears that this cycle has gone on for at least a couple of generations. The therapist's goal is to give the daughters an opportunity to create a new pattern whereby they can separate and express themselves as authentic individuals. In the following excerpt, the therapist confronts Mrs. Murphy's enmeshment with her own mother and intergenerational enmeshment, in general. Subsequently, the therapist addresses what is missing in the marital subsystem by creating a family enactment in which Mr. and Mrs. Murphy are prompted to consider their dedication to each other as husband and wife:

Therapist (to daughters):	"How do you see your mother's relationship with your grandmother"?
Susan:	"I hate how my grandmother bosses her around. Sometimes I want to say something to my grandmother, but I don't want my mother to suffer by getting slack from whatever I do."
Annie:	"I just tell my grandmother off. I don't care anymore."
Therapist (to Mr. Murphy):	"What about you? How do you feel about your wife's relationship with your mother-in-law"?
Mr. Murphy:	(chuckling)"I know better than to get involved with that hot mess. I know my place. You know, in Irish families that's how we do it."
Therapist (to Mr. Murphy):	"How do you think if affects your wife and daughters when your mother-in-law takes charge? Do you think they miss your presence and your voice"?
Mr. Murphy:	"Sure, but that old battle ax won't have it any other way."
Therapist (to daughters):	"Do you feel your grandmother is in charge of everyone"?
Both daughters:	"Yes."
Therapist (to daughters):	"And what's that like"?
Annie:	"She's a b….. I wish she'd lay off us."
Therapist (to Annie):	"Can you talk to your parents about that now? Maybe you can help them see that you suffer from their not stepping up."

In the next piece of dialogue the therapist addresses the father's lack of involvement with his daughter and wife. The hypothesis is that here lies another family pattern- men sit on the side lines while women do the emotional work. Perhaps this is a coalition between the mother and daughter against the father/husband. The goal is to strengthen the marital dyad while addressing harmful mother/daughter coalitions that are being passed down multigenerationally like the coalition between Mrs. Murphy and her mother and the coalition between Mrs. Murphy and Susan.

Therapist (to Mr. Murphy):	"What happens to you when your wife cries about Susan's being anorexic"?
Mr. Murphy:	"I guess I just got used to it." (He chuckles mildly, seeming uncomfortable.)
Therapist (to Mr. Murphy):	"Can you say more"?
Mr. Murphy:	"I've always let my wife deal with the girls' emotional stuff, them all being women, and all. Then, again my wife probably just does what her mother wants her to do."
Therapist (to Susan and Annie):	"Do you all want to continue these patterns or would you rather have your parents become stronger as a couple and stronger as parents so that you girls can go off and lead your own lives and maybe someday have your own families that you're involved with"?

In the following excerpt, a structural change is created, symbolically, by changing the seating arrangement. The

new seating arrangement is in line with the structure that needs to be created– that is, mom and dad engage in an intimate relationship while sisters connect to each other and support each other in figuring out how to separate/differentiate from their parents. Here the marital subsystem is strengthened along with the sibling subsystem, and the eating disorder is reframed as a developmental issue. It is often easier and less pathologizing for families to think of their child as immature rather than sick. Reframing is also a way of telling parents that they enable their children when they overprotect them. Parents need to give the message that their children have the capacity to grow up and thrive.

Therapist: (Looking at Susan and Annie) "Would you all mind changing seats? I think your parents should sit next to each other and that you girls should, too. I believe that eating disorders are sometimes about people not feeling like they can act their age, and it seems like in your family Susan is acting like a little girl and mom is treating her like one, out of concern and love, of course, but nevertheless Susan isn't acting as competently as we all know she can be. I also think that Annie and dad are acting like a couple and, things need to be rearranged so that everyone can be in their proper place."

Annie: "I sort of see what you mean. I do wish my parents would go out like my friends' parents do."

Therapist: "What do you think about this, Susan"?

Susan: "I agree. They never do anything together."

In addition, the therapist used a structural technique known as unbalancing (Minuchin and Fishman 2009), which involves the therapist creating intensity in order to prompt a shift in the family hierarchy. In this instance, Mr. Murphy was asked to perform a task that put him on equal footing with Mrs. Murphy; namely the task of ensuring that Susan eats. The performance of this task sends a message that both parents have equal power and therefore equal ability to help and comfort Susan.

In the below excerpt, the therapist hypothesizes that Mrs. Murphy has taken in her mother's criticism in the form of negative body image and is inadvertently passing her feelings about herself onto her daughters. Confronting intergenerational passing down of poor body image helps mom maintain boundaries around her own negative body feelings:

Mrs. Murphy: "I think she got this from me. I've never felt comfortable with myself as a woman. I wear sneakers, not shoes. My mother always said I'd never meet a husband."

Therapist: "I think this may be affecting your daughters in a negative way, so I wonder if we can explore this in a private session with just you and your husband."

In conclusion, the therapist worked with this family for over 2 years until Susan's eating disorder symptoms completely abated and she went off to college in another state. The author believes family treatment was more successful than merely seeing Susan individually would have been, because the family work addressed the underlying issues including mother/daughter enmeshment, the passing down of negative body image, intergenerational coalitions between parents and children, fear of separation and undeveloped marital relationships.

Case Vignette # 2

The second vignette showcases a modified experiential approach, applying the couple's work of Sue Johnson to family dynamics in eating disorder families while also maintaining the hierarchical structure proposed by the structural theorists.

This case involves a family with a 17-year-old daughter who had been hospitalized with anorexia and cutting. Nancy was the only child of a wealthy, upper- middle-class, white, Protestant family. Both parents were Ivy League educated and Nancy was attending a private school. There was a great deal of family and external pressure to be the best. There had been several sessions with the parents alone and with Nancy, addressing psychoeducation about eating disorders and helping them think about how perfectionism may be affecting her. After several sessions the therapy shifts to dealing with the relationships in the family.

In the following session, the father finds out that Nancy, the IP, has lied about spending time with a friend, a friend whom the father and mother consider to be a negative influence on Nancy. The main family dynamic involves a hot-headed father with a very strong personality and a passive teen who does not use her voice, but instead speaks through her eating disorder, and a mother who feels ineffective in making change. The mother is Mrs. Smith, the father is Dr. Smith, and Nancy is their 17-year-old daughter. Both structural and experiential work are used in this session. Goals in the therapy include helping the parents work together (parenting subsystem), strengthening the daughter's voice while quieting the father's, bringing out repressed emotions (both primary and secondary), noting destructive cycles, and keeping conversations going between family members (enactment).

Therapist: "Hi everyone, (all sit down) so, is there anything you would like to talk about"?

Dr. Smith (to Nancy): "You are a liar, you cannot be trusted. How could you have told us you were going out to get some school stuff and then gotten together with Judy? (louder and yelling) I asked you where you were going and you said out to Target by yourself and then you were coming home and I caught you at Starbucks with Judy and then out for coffee with her. It was a lie and you are untrustworthy and what were you thinking"??? (yelling)

(Daughter, Nancy, is very quiet, shut down, head down)

Dr. Smith: "Well, are you going to admit it, tell what happened, are you going to answer"?

(Daughter is silent and curled up. Mom is silent)

Here there is a cycle in which the father is upset, loud, and critical and although the daughter may try to speak, she feels quickly shut down by her father. The mother removes herself from the fray. She is also silent, somewhat uncomfortable with the father's anger and unsure as to how to effect the situation in a positive way. Here the therapist decides to focus on the father/daughter relationship, with the intention of bringing the mother in later on. Because the father is likely upset and scared, the goal is to help him express his softer, more vulnerable emotions, with the aim of bringing his daughter closer to him.

Therapist: "Okay, hold on a minute. I think I understand the story and what happened. So, Dad, when Nancy said that she would be alone, and you then saw her with a friend when you drove by the coffee shop, you were really angry and I see you are feeling that anger now. Your concern about the lie is that she was hanging out with a friend who you knew contributed to her eating disorder and the friend was also someone she used to drink with, so when you saw that she was with that friend and did not tell you the entire truth you were angry, and was there anything else you were thinking and feeling"?

Dr. Smith: "I don't know…that she would drink again and the lies would begin and we would not know what was going on and she may end up back in the hospital. Just thinking of it makes me so angry." (he begins to seem more agitated)

Therapist: "So after having such a hard year with your daughter, not knowing if she was going to be okay or not…and all the worries you experienced… she is doing better, back in school, getting good grades, feeling better…so seeing her with Judy and the lie…brought you back to that place and you were very, very angry…even just thinking about it makes you angry…but you also said you were concerned and it seems like perhaps, I wonder if you were scared of her going back to a bad place."

Dr. Smith: "Yes, that is exactly right."

It is important to validate the father's anger and also to expand his story with compassion, so he feels heard and understood. Then the therapist can get to the more primary emotions. Dr. Smith seemed to agree with the fear (primary emotion) which is at the heart of things for him, and an emotion Nancy and Mrs. Smith will be more able to hear and understand. It is also important for them to try to speak more directly to each other (enactment).

Therapist: "I think perhaps you were really scared…scared of her going backwards after so much hard work and you being able to relax in thinking that maybe she will be okay. You love her so much that it scares you something could happen to her."

Dr. Smith: "Yes…"(quiet voice)

Therapist: "I think sometimes when you are worried and scared it comes out with a lot of anger, and then Nancy withdraws from you, and then you get more angry—it's that destructive cycle we mentioned briefly last session. I am wondering if you would feel comfortable telling Nancy about your fear"?

Keeping the conversation going is very valuable here. Helping family members speak directly to each other about difficult topics (enactment) gives them the practice and confidence to continue the process at home.

Dr. Smith: "You mean right now"?

Therapist: "Yes, if you are okay with it."

Dr. Smith: "Well, I guess. Nancy, I do get scared…we went through so much last year, it was hell. We just want you to be healthy so when I saw you with Judy, I just saw you right back in the hospital. I actually was not scared, I was terrified"!

Therapist: "Keep going, you are doing great."
Dr. Smith: "I really care about you. You mean everything to me and seeing you lie…or with her, I just felt devastated. Like we were all going to go back to that really hard place. I guess I do sometimes get angry when I am scared."
Therapist: "Nancy, what is it like for you to hear Dad say this"?
Nancy: "Well it is much easier to hear than his anger."

In the following dialogue, the therapist helps Dr. Smith understand that Nancy is not just being defiant when she shuts him out. In this case, Nancy's anger (secondary feelings) needs to be validated. Again, the therapist tries to get them to speak to each other.

Therapist: "What happens for you when dad gets angry…like last night after Starbucks when you were with Judy"?
Nancy: "Oh, he is like a maniac. I could not even speak."
Therapist: "What do you do when he is like that…or what did you do last night"?
Nancy: "Oh, I just get away from him…I locked myself in my room and he just kept screaming through the door. I put my headphones on to block him out. That's what usually happens and then he just yells more."
Therapist: "So what was happening for you when you were in your room with your headphones and he was screaming through the door"?
Nancy: "I dunno…I guess I got scared, and angry."
Therapist: "Maybe you can say a bit more so he really understands what it is like for you when he yells, you can do it. It is important that he hears you."
Dr. Smith: "Tell me."
Nancy: "You are scary, Dad…I never want to see or speak to you when you are like that. I feel so small. And I feel angry, it happened so much before I went into the hospital."
Therapist: "So when dad screams loudly like the way he did that night you try to get away from him, you do not want to engage with him…and you get angry and he can also be really scary so of course you want to get away. But when he spoke to you like he did a few minutes ago, it did not feel like you needed to run away…it was not scary or angering—Is that right"?
Nancy: "Yes."

An important question at this point is what is mother's role and what happens to her during this time when father and Nancy are in a destructive cycle. Is there something she can do which can affect things in a positive way? Here, the therapist wants to strengthen the parenting subsystem, and also help the family understand what is happening for mom internally.

Therapist: "I am also wondering as we speak about you Mom, when you are there…what usually happens for you when Nancy and dad are fighting, like last night"?
Mrs. Smith: "I understood why my husband was angry and upset and scared…I was too…but when his anger is strong, I kind of stand back as I am not sure there is much I can do to calm him down. I don't feel I can help either of them."

Mother is clearly scared of father's anger and becomes passive and ineffective and that is her part in this vicious cycle. The mother needs to take a stand, but also work with her husband as a parenting team. These are some structural changes that need to occur.

Therapist: "Well I wonder, Dad, when you are in that anger state, is there is something your wife can do or say to help? You are partners working together to help Nancy. Can you both talk about this with each other"?
Dr. Smith: (facing his wife) "I don't know, maybe you could tell me to take a 5 min break in the other room and calm myself before speaking to Nancy."
Mrs. Smith: "I could try, just to remind you it's not helpful when you yell. (Looking at therapist) But when he gets like that he does not hear anyone."
Dr. Smith: "You know I have been working on being less angry, I have gotten better, so I hope I can. I need a reminder from you."

Before the session ended, Nancy discussed things she might do to feel more empowered when her father is angry. Over time the father continued to work on his anger, expressing more primary emotions, while mother became more active and reminded/helped the father. The family was aware enough to stop the destructive cycle and all members continued to work hard on clear communication. Several months after this session, when another difficult situation arose in the family, they were able to work it through at home and entered therapy proud of their new skills. After several more months of therapy the family

structure and communication significantly changed. Nancy was no longer struggling and was doing well in her life and applying to college.

An eclectic model was used with this family. Although the intergenerational transmission piece was worked on in future sessions, both structural and experiential concepts were the focus here. From a structural perspective, helping both parents work together and support one another was essential. However, the experiential work was the pivotal part of change for the family. First of all, the therapist reintegrated the mother into the family dynamic by having her help the father calm his anger/anxiety. When they got stuck, the therapist supported and encouraged the father to speak directly to his daughter, from a place of concern, as opposed to anger. This change in emotion helped his daughter to hear him and come closer to him instead of moving away. It also allowed her to feel comfortable using her voice in expressing both her anger and needs. Otherwise, holding in her feelings and desires might have further contributed to her continued cutting and starving. Using words and expressing feelings—while her father listened compassionately—turned things around. The destructive cycle described had ended.

Conclusion

Although individual work helps the eating disordered individual manage symptoms and develop coping strategies, family work addresses the underlying dynamics that inadvertently give rise to an eating disorder, or hold it in place. When family dynamics are not significantly changed, symptoms can return, be transferred to another family member and/or be passed down intergenerationally. The authors posit that an eclectic model; which incorporates systems theory, emotionally-focused work and structural work; is a useful model for helping families deal with the complex family dynamics that often accompany eating disorders. This model is especially recommended for cases in which IPs are living with their parents and the therapist must attend to both the adolescent's need for autonomy *and* the need to strengthen adolescent-parent attachment as preparation for a healthy separation. Although many other family treatment models exist, the authors chose these three theories based on their own clinical and teaching experiences with families. They feel that each theory contributes something unique and significant. Systemic work focuses on the past and repeating patterns, as seen in the first vignette. Structural work gives an easy and valuable way to assess and treat a family. Finally, experiential work provides an in-depth focus on feelings/communication. Having an eclectic model from which to draw upon is a helpful way to approach family work.

Regarding the two vignettes presented, the authors believe that without family therapy, healing would have been limited and recidivism could have been likely. In changing relational dynamics, both families were able to shift the behaviors and communication styles which contributed to the IPs' eating disorder behaviors. In both cases the following relational changes occurred: children separated from parents and were able to develop their own voice while engaging in clearer communication; parents started working together, and expressing more vulnerable emotions to their adolescents and to each other.

Unlike individual therapies like medication and CBT, family therapy does not have the same research base. It can also be more challenging and time consuming to learn and is not always required by social work schools. As compared to other therapy models, it is not always a teachable step-by-step approach. The authors posit that family therapy is best taught by tutelage or mentoring, which takes time, thought and commitment. As a result, many clinicians do not receive the necessary training. The authors advocate for clinicians to get further training, if desired, or to make referrals to family therapy practitioners when working with eating disorders.

The therapist's office provides a safe environment, and, for many, a corrective emotional experience. Tools, techniques, and a better understanding of the self are healing for individuals struggling with eating disorders. But everyone must eventually leave that office and return home to a family. Does that home provide the safe, nurturing environment ideal for someone who is struggling with an eating disorder? Family therapy goes beyond individual healing and changes environments, making them healthier and more growth-promoting. If family treatment is successful, the safe, holding environment of the therapist's office can be transferred to the family hearth.

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