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**Treating Eating Disorders at  
Midlife and Beyond:  
Help, Hope, and  
Relational- Cultural Theory**

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Treating Eating Disorders At Midlife and Beyond: Help, Hope, and Relational Cultural Theory

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**Abstract**

Although research is scarce, increasing numbers of midlife and older women are seeking eating disorders treatment, despite prevailing beliefs that these conditions only affect the young. Body satisfaction used to increase with age, but today 65 percent of midlife women express significant weight preoccupation and distress over their shape, appearance, and diet, threatening the health, well-being, and status of women across the globe. Many adult women hide their disorder effectively; others may have years of semi-recovery or subclinical symptoms, with the multiple stressors and transitions of midlife triggering relapse. Ashamed, embarrassed, and ambivalent about seeking help, midlife women face more obstacles to treatment due to other responsibilities and commitments. Motivation for recovery is also more complex, as midlife women bring increased knowledge from life experiences and long to release themselves from their eating disorder identity. This paper explores the *Relational-Cultural Theory* model of growth fostering relationships and mutuality as keys to recovery for adult women. *RCT* understands eating disorders as strategies of disconnection resulting in chronic isolation from meaningful engagement with themselves, their body's needs, and their relationships. Many adults come into therapy acknowledging their eating disorder no longer works for them, but doubt they can recover after decades of suffering or poor response to other treatments. *RCT* examines the meaning and function of the eating disorder through the lens of these adult relationships, distinct from the objectification of the medical model. The concept of *fluid expertise* (Jordan, 2010) values that both client and clinician bring wisdom and knowledge to build upon mutual understanding of these disorders and create new pathways towards recovery.

### **Eating Disorders Across, Age, Race, and Ethnicity**

For both highly trained health care professionals and the average person, the face that comes to mind when eating disorders are mentioned is usually young, white, and female. Today, however, the face of eating disorders is far more diverse, especially regarding age, race, and ethnicity. These are no longer disorders for affluent white teens and college students in the advanced developed nations. Instead they occur across age, race, ethnicity, class, culture, and place; now globalized, they are found in over 40 countries, including developing nations (Gordon, 2001). Despite this increasing diversity, gender alone remains the single-best predictor of their risk (Striegel-Moore & Bulik, 2007). In fact, anorexia nervosa and bulimia nervosa are still ten times more common in females than males, and binge-eating disorder is three times more common (Treasure, 2007).

Both clinical impressions and research now confirm that age does not immunize women from body image preoccupation and weight concerns as has been thought in the past; in fact, disordered eating and a fear of aging go hand-in hand for many women (Lewis & Cachelin, 2001). Surveys of women aged 61 to 92, asked what bothered them most about their bodies, identify weight as the greatest concern (Clarke, 2002), despite the many other physical issues aging women face. In a random non-clinical sample of 1,000 Austrian women, all average Body Mass Index (BMI), 4% met the criteria for eating disorders and another 4% were subclinical (Mangweth-Matzek et al., 2006). Furthermore, 80% “controlled their weight” and 60% reported body dissatisfaction. In another survey, 75% of American women, aged 25-45, report disordered eating and body image dissatisfaction, and 67% were trying to lose weight, although over half of these dieters were already at a normal weight (Bulik & Reba-Harrelson, 2008). Clearly, body dissatisfaction and disordered eating are the new norms for adult women. Western culture, and

now the globalized consumer culture, takes advantage of women's desire to look young and to avoid the loss of power associated with an ageing female body. In this cultural environment, body image obsessions, dieting, and weight loss bring highly desired secondary gains that are difficult to abandon as women age.

Current research also confirms that eating disorders are increasingly found in diverse cultures historically thought to be protected from pressures related to body image and appearance. Grabe and Hyde's (2006) meta-analysis of 98 studies, finds no significant differences in body dissatisfaction between Caucasian, Hispanic, and Asian women in the US. Also, Bisaga et al. (2005) report similar rates of disordered eating across ethnicities in adolescent girls. Despite this growing diversity of eating disorders, minority women experience worrisome barriers to their access to care, especially due to lack of recognition by providers (Cachelin & Striegel-Moore, 2006). These outdated stereotypes keep women from receiving appropriate diagnosis and lifesaving care.

Culture, ethnicity, difference, and eating disorders affect non- white and non-western females in very unique ways, as described so well by Nasser and Malson (2009):

The spread of thinness as a master signifier of feminine beauty, promulgated by the mass media and the post-colonial operations of transnational capital, across all sections of western societies and across the world has been devastatingly effective in the 'globalization' of 'eating disordered' subjectivities and practices.... Thinness as a gendered body 'ideal' and a signifier of a multiplicity of positively construed 'attributes' can clearly no longer be considered exclusively western or white (p. 82).

Nasser and Malson (2009) advise us to attend to both the global and the local factors in our attempts to understand eating disorders. For example, they explain that the “gendered aesthetics of thinness” are not always central to the disordered eating and that other “locally-specific discursive constructions of self-starvation may be more relevant” (p. 82). While mental health clinicians generally understand how western factors create risk for eating disorders, they may ignore the possibility that non-western factors also are at play, some of which are protective, while others increase risk (Keel & Gravener, 2008). For example, Hoek et al. (2005) report that, “despite rapid cultural transition” (p. 44) and exposure to western culture and influences, women in the predominantly black Caribbean island of Curacao seem to be protected by traditional cultural preferences for larger bodied women. The incidence of anorexia nervosa in Curacao reveals very specific patterns. While no cases were found in the black women, the rate of anorexia in mixed race and white women was commensurate to the rate in the US and Netherlands. All of the women who presented with anorexia nervosa had been abroad for at least a year, generally prior to the development of the symptoms.

Some surprising research indicates that eating and weight concerns may be higher in Asian countries than in western nations (Wardle, Haase, & Steptoe, 2006), suggesting that non-western values may also contribute to the risk for eating disorders. Jackson, Keel, and Ho Lee (2006) compared native, immigrant, and second generation Korean Americans. Disordered eating was higher in native Korean women and Korean immigrants than in the Korean American group. In other words, those most immersed in western culture had the lowest incidence. Such a counter-intuitive finding may reflect specific and unique cultural values and traditions. For example, both Korean and Thai gender roles stress the importance of women marrying into prominent wealthy families and appearance is critical and highly valued (Jennings, Forbes,

McDermott, Hulse, & Juniper, 2006). The unique combination of increased exposure to new, western and traditional, non-western values, all emphasizing appearance, may increase risk for eating disorders. Furthermore, according to Kusano-Scharz and von Wietersheim (2005), collectivism, the preference for group versus individual needs/desires, is a traditional value in Asian cultures. They speculate that the rates of eating disorders in Japan may reflect the intersection of unhealthy ideals with a culture that promotes meeting social expectations or values over their individual needs.

Clearly, eating disorders no longer belong to a place or a life stage, but instead inhabit many different and constantly evolving global social spheres and developmental periods. This paper assumes that *Relational-Cultural Theory* (RCT) will best inform our understanding of these problems, helping us to answer: why women; why now; and how can we help?

#### **Eating Disorders at Midlife and Beyond: Out of the Closet and into our Offices**

Five women sit expectantly in the treatment room as we begin a therapy group focused on midlife eating disorders. They represent the spectrum from Anorexia Nervosa, Bulimia Nervosa, Eating Disorders Not Otherwise Specified (EDNOS), Binge Eating Disorder (BED), and symptom remission. Each is nearly in tears of relief, sharing how good it feels to be with “other women like me.” After decades of therapy, hospitalizations, and residential treatment, these women are now claiming recovery for themselves and are eager to talk about it.

Increasing numbers of midlife and older women are presenting for eating disorders treatment. Some received treatment at earlier stages of the life cycle, but most describe previous attempts at therapy that never addressed their eating disorder. Almost all report that their medical providers did not identify or treat the eating disorders, even when patients reported disordered eating symptoms and physical complications. Now, some 30 years later, sufferers are

seeking experienced treatment providers. Attention from the news media has raised public consciousness about the frequency of adult women who suffer from disordered eating and body image distress, perhaps explaining this trend.

While conventional wisdom suggests that chronic eating disorders should be resistant to treatment, it can be quite the contrary, as more and more skilled therapists, informed by decades of experience and refined relational skills begin to work with adult patients. Adult women, however, require different relational responses than younger patients and we need to better understand the specific *relational* requirements that empower their recovery.

### **Disconnections in Eating Disorders**

*Relational- Cultural Theory (RCT)* posits that eating disorders serve as a strategy of disconnection resulting in chronic isolation (Tantillo & Sanftner, 2010a). The behaviors resulting from this isolation serve to further separate the individual from meaningful engagement with themselves, their body's needs, and their relationships. The "habit rigidity" (Strober, 2011) of decades of symptoms adds to the challenge. Many adult women have hidden their disorder effectively since their teens. Some may have years of semi-recovery. Others may have sub-acute symptoms in the background, describing decades of hiding restrictive eating under the guise of diets, excess exercise, and binge-purge cycles. Adult women spend years denying their true appetites, hungers, and feelings, and treating their bodies punitively. Disconnection becomes normal and comfortable, despite its danger (Piran & Cormier, 2005).

Eating disorders typically first appear during periods of developmental transitions, so the peak incidence periods are early and later adolescence (ages 13-15 and 17-19). Transitions create risk for developing eating disorders at any point in the lifecycle, however. Midlife is risky because it is full of transitions, some of which are physical (pregnancy, fertility issues,

menopause, or aging) while others are more psychosocial (divorce, losses, aging parents, competition in the workplace, retirement, or empty nesting). These and other transitional times intensify the vulnerability for adult women to develop an eating disorder, to relapse, or to intensify ongoing symptoms (Maine, 2010; Maine & Kelly, 2005).

### **The Role of Shame**

Shame is one of the most powerful deterrents to getting help, for all women with eating disorders. Exhausted by the effects of the eating disorder, adult women are usually deeply embarrassed about having “a teenager’s problem,” and, therefore, more ambivalent about whether they “deserve” or will benefit from treatment (Maine & Kelly, 2005). In our clinical experience, admitting profound difficulties in their relationships with food and with their bodies is far more intense in adult eating disordered patients. Far more women will present symptoms of depression and anxiety as their primary concern, and minimize the profound shame related to their chronic or recurring eating disorder. Constantly berating themselves, they usually feel that their problems are less legitimate than a younger woman’s and that they do not deserve help. Also, with their multiple and complex roles, midlife women have seemingly endless everyday responsibilities, with more people to take care of, and, perhaps, to disappoint, if they do start paying attention to their own needs. Under constant stress, they may find the ritualized behaviors of eating disorders comforting and grounding, despite the long-term threat to their emotional and physical health. Most adult women rarely mention their eating disorder to their physicians or health care providers, another place of shame and humiliation. When they face the “dreaded” scale at each medical visit, many describe the long held fears that surface with this reminder. Yet, this simple act of stepping on the scale activates states of disconnection.

With its deep recognition of the destructive power of chronic disconnection, the relational-cultural model of treatment addresses the profound issue of shame and unworthiness, thereby being especially fitting for adult women with eating disorders. Encouraging an adult woman to speak to her medical provider, seeking support for her recovery, becomes an act of courage and risk taking. The therapist encourages and models mutual engagement, offering relational hope, a motivational stance, and compassion for the states of disconnection that occur so frequently in adult women's daily lives.

Tantillo and Sanftner's (2010b) Connection-Disconnection Scale, further elucidates how a perfect storm of biopsychosocial factors predisposes a vulnerability to eating disorders. In women who chronically experience states of isolation and shame, the resulting assumption is that self-empathy and mutuality, especially in regards to their struggle to feed themselves, remains unattainable. The dominant culture dictates both standards of beauty and the body ideal, and shames those who struggle to regulate appetites and self-care. When the struggle has been perpetuated into mid-life, the desire for recovery has long been intermingled with shame and humiliation.

Judith Jordan (1986, 2004) reminds us that shame is essentially a relational experience. Shame is understood as a sense of being profoundly unworthy or undeserving of empathy and of being in (good) connection. As experienced therapists, we must attend to the subtle ways shame remains an oppressive force confounding recovery. In the words of K. Laing, (1998), "isolation is the glue that holds oppression in place." Thus, relational therapy, with a non-judgmental approach, offers the pathway to appropriate risk, reigniting the hope of empathic possibility. The courage to move away from the secrecy and isolation of the eating disorder, serves as the antidote to shame, with the woman moving from fear and condemned isolation, towards

empathy, both in therapy and in the development of self-compassion. Sanftner and Tantillo (2011) describe:

*Helping clients through the vulnerable state that shame evokes requires making an empathic connection that helps them feel that their fragility and helplessness are okay, that they can survive these feelings, and that they will not make the therapist turn away. (p. 20).*

### **Motivation for Recovery**

At midlife, motivation for recovery is more complex, as women bring increased knowledge from life experiences and long to release themselves from their eating disorder identity. Mothers often describe their children as the inspiration to resume treatment. They want to parent more effectively, better than they have been able to care for themselves; they are determined the “cycle will stop with me.” Their “secret” relationship with their eating disorder competes with every aspect of their lives, systematically robbing them of their passions, their pleasures, and their plans. Although anxious and unsure, they want to reclaim all of these, and, with a seasoned clinician steeped in a relational approach and well-informed about eating disorders, they can.

Women who are mothers frequently vacillate between competing fears: that their children will be harmed by their eating disorder, or they will develop one because of them. Often the greatest terror is being discovered so they live determined not to let anyone know, again surrounded by shame and isolation. The therapist helps to model the power of naming, moving away from the fear of further punishment and self-recrimination. Finding the voice to name the disorder, to describe their recovery, to ask family and friends to actively join their treatment team and step out of the shadows, becomes possible within the relational frame that encourages these

steps. These repeated actions, from chronic states of disconnection towards connection, again and again, foster new neural pathways of healing. Therapy offers the safe place to understand the array of distressing states, without retreating to the psychic numbing and self-harm of the eating disordered symptoms.

### **Relational Resilience**

Adult women come into therapy acknowledging their eating disorder no longer works for them, seeking recovery with renewed, but very tentative, vigor. Our job is to build on that vigor in the form of relational resilience. Unlike the traditional separate self-concept of resilience as “bouncing back” to some previous time of individual competency, relational resilience is the capacity and courage to move towards re-establishing mutuality and trust in relationship. To learn and establish healing connections moves one away from isolation, towards relational possibility and the capacity to acquire new skills for recovery. Mutual empowerment emerges, which allows both client and therapist to experience more aliveness, more clarity, and a greater sense of possibility (Jordan, 2010). The pervasive isolation at the center of suffering with an eating disorder lessens, as the possibility of healing connections emerge. The question is: can women recover after 30 or more years of suffering? As clinicians devoting significant time to working with adult women with a wide range of eating disorders, we answer this question with a loud, unequivocal “*YES.*”

Over the last few years, colleagues echo our experience of learning more about the recovery process in treatment with women in mid-life. While the symptoms and physical sequelae may not differ greatly from their much younger sisters, the meaning of the eating disorder requires examination through the lens of their adult relationships. Recovery implies coming into voice, speaking their mind, and in many cases “upsetting the apple cart” (A. B.

Dennis, personal communication, 2011). Experienced therapists bring our own cumulative knowledge and wisdom from working with these complex concerns. *Fluid expertise* describes a relational concept of honoring the idea that both people bring wisdom and knowledge to an exchange (Jordan, 2010). The therapeutic connection allows both client and therapist to build upon the mutual understanding of these disorders to create new pathways towards recovery.

### **Treatment Tools**

In our efforts to capitalize on their motivation to find changes that work, we have developed a few key questions to understand the core concerns of women in midlife with chronic eating disorders.

1. What are the variables that have changed in midlife that promote increased motivation for recovery from the eating disorder? What has been helpful to move you over the line towards recovery?
2. What do you **now** know that you did not know or understand as a child or teen when the eating disorder began? What would you tell your child self from the vantage point of today?
3. What are the challenges still to be faced in order to recover?

These questions are best explored within a strong therapeutic relationship grounded in a Relational-Cultural model. Western culture promotes the ideal that human psychological development evolves from dependence to independence. Many of our adult patients have been successful in their attempts to need little from others, nurturing instead a disordered relationship with food and their bodies. In fact, women with low levels of mutuality are more apt to develop eating disorders (Jordan, 2010; Sanftner et al., 2006). Adult women with eating disorders may experience mutuality in other areas of their lives, but rarely when it comes to their struggles with

food, weight, and shape. *RCT* challenges the paradigm of a separate self and suggests that growth fostering relationships are essential to development as human beings grow through, and toward, connection.

We need connections to flourish, even to stay alive; isolation is the major source of suffering for people (Jordan, 2010). Mutual empathy allows each person to see, know, and feel the responsiveness of the other person. Mutuality involves mutual impact, mutual care, and mutual responsiveness (Jordan, 1986, 2010). The *RCT* therapist engages with the client, able to discuss their differences, the moments of connection, the disconnections, and how we are moved and learn from one another by engaging in the repair (Tantillo & Sanftner, 2010 a). See Table 1 for suggested strategies to increase mutuality and motivation.

#### INSERT TABLE 1

Jean Baker Miller conceptualizes mutual empathy as the core process leading to “the five good things” of growth fostering relationships: a sense of zest; a better understanding of self and others; improved self-worth and validation; enhanced capacity to act on behalf of oneself and others; and a heightened desire for more connection (Miller & Stiver, 1997). These are the essential building blocks of treatment for women with eating disorders at midlife.

The opposite of the “five good things” produces chronic disconnections that can range from minor injuries (feeling ignored or misunderstood) to serious and persistent disconnections such as chronic invalidation, neglect, or sexual, physical, and emotional abuse. States of chronic disconnection contribute to what Miller described as “condemned isolation,” when the individual cannot seek effective strategies to move back towards mutuality (Miller, 1988). Chronic eating disorders, as well as chronic mood disorders, are the result of this recurring

experience of being shut out of the very relational connections that are valued, sought after, and longed for.

### **Clinical Vignette**

The following clinical vignette describes the journey of one woman at midlife in her quest to reclaim her life from the grips of a nearly lifelong eating disorder. Our partnership in treatment developed slowly, based on a combination of psycho-education about the relational model of therapy as described above, my nearly 30 years of training and experience in the field of eating disorders, my respect for her experience, and her own expertise in knowing what would help her.

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*Paula, 48 years old, first developed symptoms of anorexia at age 15. She sought help from her mother but was shamed and humiliated instead: “you’re on your own” was the message. A pattern of blame and denial pushed the problem underground and in the 1980’s little information was available about the dangers of eating disorders. She sought therapy in college as the restrictive periods of anorexia gave way to increasing binge eating and methods of purging. After college, she kept her disorder well hidden and managed to work and enjoy the new “freedoms” of adulthood. However, days would be lost to her symptoms and jobs would be lost with too many absences.*

*Finally a therapist suggested residential treatment. At 43, she was “sick and tired of the secrets and suffering.” Upon discharge it was recommended that she find a therapist who specialized in eating disorders and she entered treatment virtually mute about her eating, her body hatred, and her fears. She was the picture of compliance with recommendations from her treatment team ( psychologist-KS, psychiatrist, primary care physician and registered dietician),*

*but too terrified to ask questions. She judged herself as incompetent, a therapeutic failure still struggling with her eating disorder as she neared 50.*

*In therapy, the concept of fluid expertise and mutuality in relationships was emphasized. A collaborative, relational “we” evolved. Therapy began with many reminders that the therapist was not going to “fix her” eating disorder. We would work together to learn what helps. Like many adult patients, sometimes she would ask: why she struggled; how come the eating disorder was so stubborn in letting go; how long would it take to quiet the eating disorder voices; was recovery even possible? The therapist often offered the humble reply: “I don’t know,” but suggested that together they would seek answers to these questions. The therapist repeatedly refused to assume the “power over” position of a critical judge or expert, working steadily in a “power with” alliance. This empowered Paula to voice the many ways she deemed herself too inadequate to recover.*

*Example by example, we reviewed the ways she had become a harsh self-critic. Slowly debunking these self-imposed punishments, Paula began to allow herself to make mistakes and to become disappointed, without sinking into depression and self-harm. The years of shameful isolation had perpetuated the conviction that she would inevitably disappoint anyone she felt close to, including her therapist. Paula was convinced her treatment team would grow weary and give up on her. Each perceived micro-aggression, or disconnection, a questioning look, a comment, a challenging problem at work, even a compliment, would trigger the shame again. Repeatedly we named these moments when she lost her power, fell into the familiar silence of self-recrimination and shame. Paula learned to follow her recovery plan, rather than abandon it, during these painful moments of disconnection. Connected to her plan, to her team, she became more resilient. When asked to name “one true thing” she better understood about*

*herself in recovery, she would respond most often with the reminder: “Do not do this work alone.”*

*Over the next few years Paula gradually found “her voice” and began speaking out. First she spoke to her spouse, including him in her various treatment team meetings. Next came speaking up to friends and co-workers, educating them regarding comments about her food choices and weight fluctuations.*

*She began to realize how external factors had fueled her eating disorder and disempowered her. For example, her employer had instituted a “wellness program” that financially incentivized employee weight loss. The company had rewarded her with a bonus during her most difficult period of re-feeding and weight restoration, when she had lost weight to a dangerously low level. She asserted herself, writing a letter of protest indicting the company’s “weightist” attitudes, explaining her personal struggle to regain and maintain an appropriate weight. She further outlined the dangers of Anorexia Nervosa, pointing out the error of a “bonus” for a life threatening disease. She continued to challenge the extreme diets the company encouraged under the guise of health promotion.*

*Now in an adult eating disorder group, she offers hope to others and draws wisdom from them as well. The power of naming, asking for empathy and learning to receive it, then learning to extend herself to others, gradually offers healing connections. New behaviors are formed, new coping skills acquired. The echo of “I have to figure it all out by myself” has faded. She still falls into that old place of isolative shame occasionally, but has developed a capacity for connection. She moves towards others and sees she has touched the lives of others on her journey.*

*The temptation to retreat has gradually receded for Paula. She now recognizes and voices her struggles and success. Each day is a challenge to keep working towards authenticity and empathy for herself and her loved ones. For months we sat in silence, followed by lengthy emails full of the content she could not articulate in sessions. Paula now recognizes how anxiety triggers her symptoms and has a variety of skills and relationships she draws upon to reduce distress. She says emphatically: “going back is not an option” and claims the “five good things” and more in her life. Paula embodies patience; months of silent sessions have transitioned to spirited debates about how she is revitalizing herself and her relationships.*

*She knows she must eat: she must maintain her recovery in order to sustain her life. She moves toward mutual engagement in her daily life, nourishing her body, taking up space, gaining emotional strength; these efforts work hand in hand with leaving behind the disordered eating. Paula’s identity is no longer defined by her eating disorder. She has resumed her previous creative pursuits, invested in friendships, and now invites others into her life, pursuing new and old interests.*

### **Summary**

As therapists working with eating disorders, we find ourselves the most challenged, the most engaged, and the most satisfied when working with adult women. We are inspired to be real and fully present “women of substance” (Maine, 2010) to them, staying present without judgment as they talk about their struggles, self-doubts, and perceived inadequacies. Working with adult women requires shared power, instead of a “power over” model that elevates the clinician and disempowers the client. Both the transference and the counter-transference are based in empathy and a spirit of working together, dramatically different from the traditional

medical model (Maine, 2009). The transference relationship is much more of a “shared journey” of connection than in non-relational treatment where the clinician is the only expert present.

*RCT* also includes exploration of what it has been like to be a woman in contemporary culture.

This framework helped Paula to see herself as less “sick” and more capable, empowering her in new ways as seen in her challenge of her company’s policies about weight.

This model also keeps us “on our toes,” being aware of how we as women (or men using *RCT*) also have responded to our culture’s expectations and roles. Thus, we find ourselves on a parallel track of growth and development as women. We must remember to engage in our own self-care, to seek the counsel of our colleagues, to continue to create the “five good things” in our own lives. In the words of Jean Baker Miller: “the zest of being in connection” re-energizes and informs our work and our lives. To be engaged in a growth fostering connection based in mutuality offers therapists a model to join with women who have suffered alone for decades. As they change, we also move forward and learn: mutual growth is a hallmark of *RCT*. This is exciting and heartening work and we hope that others will join us in our answer to the perennial question: is recovery possible after 30 or more years of suffering? *Yes. Hope is alive* every day in our treatment centers, demonstrated so gracefully and powerfully by Paula.

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Table 1

Therapist Strategies to Increase Mutuality and Motivation

- Relationally reframe the illness and recovery. Educate regarding biopsychosocial risk factors that create a vulnerability to disconnection from self and others and possible development/maintenance of eating disorders.
- Externalize the illness from the patient and family.
- Acknowledge the burden/strain incurred by the illness.
- Normalize instead of pathologize patient and family experiences.
- Use validation and avoid shame and blame.
- Be empathic and warm while being deliberate and consistent.
- Be real, genuine, and emotionally present and responsive.
- Build and empower the “We” - put connection at the heart of the relationship.
- Teach and model that lapses and mistakes are opportunities for learning.
- Provide anticipatory guidance (regarding development, the illness, recovery).
- Acknowledge and apologize for errors.
- Convey humility, use well-timed humor, and foster collaboration.
- Build a new culture of shared meanings through learning the language and values of family and patient related to illness, recovery, and relationships.
- Judiciously use therapist self-disclosure to convey how patient and family have moved you in the session.
- Teach and model flexibility, openness to change and difference, and the ability to tolerate uncertainty, unpredictability and ambiguity.
- Name all or nothing thinking and its contributions to disconnections.
- Name relational dilemmas and let patients/family members see how you are thinking and feeling, while helping them name their own experience.
- Help patient and family name points of tension and disconnection and one’s responses to these events.
- Teach/model the importance of not assuming what others think/feel. Check it out.
- Honor difference and the integrity of connections with one another.
- Emphasize that all relationships naturally move from connection to disconnection and back and that there are no perfect relationships. The best ones come from continual hard work and repair.
- Be aware of your own strategies for disconnection, e.g., intellectualization, etc.
- Encourage opportunities for connection that don’t include the eating disorder.
- Remind patient and family that they are more than the eating disorder. Identify their strengths.
- Help patient/family members identify family values and goals and how the ED helps or hinders them from living according to these things.
- Help patient and family identify supports with whom they experience mutuality.
- Engage in your own self-care and with personal and professional supports with whom you experience mutuality.

(Tantillo & Sanftner, 2010, p. 325)