# Music Therapy with Middle-Aged Adults with Eating Disorders: A Critical Review of the Literature and Recommendations

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I am amazed that I have finished, and that these two years have just flown by. I will cherish all the guidance I have received, and the memories with the wonderful people I have met. I am grateful for everything. Cannot wait to see what the future has in store!

**Table of Contents**

**ABSTRACT**

Music Therapy with Middle-Aged Adults with Eating Disorders: A Critical Review of the Literature with Theoretical Recommendations

Danielle Szulanski, MT-BC

Florence Ierardi, MM, MT-BC, LPC, Advisor

This critical review of the literature was aimed at examining and synthesizing existing research and clinical publications for the purpose of making recommendations for music therapy treatment with middle-aged adults with eating disorders. This writer explored the effectiveness of theoretical orientations derived from verbal and creative arts therapies. An important consideration is the fact that theoretical orientations that provide guidance for treatment of adolescents with eating disorders may require some modifications when applied to middle-aged adults, as is the case with theoretical orientations of verbal therapy for eating disorders. Since the existing literature regarding middle-aged adults is limited, this writer incorporated literature information concerning adolescents and young adults to better inform music therapy recommendations for middle-aged adults with eating disorders. Based upon a synthesis of the literature, this writer outlines an integrative approach involving music therapy with this population. This writer suggests that future research be aimed at measuring effectiveness of music therapy with this population.

# CHAPTER 1: INTRODUCTION

Among middle-aged adults between forty and sixty years old, Ackard, Richter, Frisch, Mangham, and Cronemeyer (2012) found that there was an 11.6% increase in prevalence of inpatient admissions. In their literature review, Luca, Luca, and Calandra (2015) found that the prevalence of late-life eating disorders in their sample ranged from 1.8% to 3.8%, and the most common eating disorder was binge eating disorder. Luca et al. (2015) also found there were similarities and differences in the presentation, assessment and treatment of middle-aged adults with eating disorders as compared to children and adolescents. In their review of the literature, Harris and Cumella (2006) reported that their treatment program had seen a 400% increase in middle-aged adults with eating disorders seeking treatment within the past ten years. There has been a growing body of research examining eating disorders in middle-aged adults (Ackard, Richter, Frisch, Mangham, & Cronemeyer, 2012; Harris & Cumella, 2006; Mangweth-Matzek, Hoek, & Pope Jr, 2014; Mangweth-Matzek, Hoek, Rupp, & Lackner-Seifert, 2014; Midlarsky & Nitzburg, 2008).

Several authors discussed the possible causes of eating disorders among middle-aged adults (Forman & Davis, 2005; Gagne, von Holle, Brownley, Runfola, Hofmeier, Branch, & Bulik, 2012; Gupta & Schork, 1993; Luca et al., 2015; Mangweth-Matzek et al., 2014; McLean, Paxton, & Wertheim, 2010; Midlarksy & Nizburg, 2008). Gagne et al. (2012) and McLean et al. (2010) found a relationship between body dissatisfaction and disordered eating among middle-aged women, and reported body dissatisfaction to be comparable to that of younger women. Gagne et al. (2012) suggested that excessive concern with dieting, weight, body shape, and overall body dissatisfaction could have

negative consequences on a woman's self-esteem, self-efficacy, and quality of life, all of which could increase the risk for developing an eating disorder. The literature suggests these factors could be due to sociocultural expectations, such as beauty and thinness (Forman & Davis, 2005; Gupta & Schork, 1993; Luca et al., 2015; Midlarsky & Nitzburg, 2008), and stressors such as death of a parent, peer or child (Harris & Cumella, 2006), divorce (Forman & Davis, 2005, Harris & Cumella, 2006), aging (Gupta & Schork, 1993; Harris & Cumella, 2006; Luca et al., 2015; Midlarksy & Nitzburg, 2008), and empty nest syndrome (Harris & Cumella, 2006). Middle-aged women also have a harder time engaging in self-care due to the challenges of increased demands and responsibilities, and internalized societal expectations that dictate that women look after others before themselves (McLean et al., 2010). Additionally, Luca et al. (2015) and Mangweth-Matzek et al. (2014) found authors in their literature who proposed that women in their late-life become more devalued by society, with a growing sense of envy, loss, and preoccupation with body image and bodily changes, such as menopause.

A middle-aged woman's menopausal transition may be associated with the increased prevalence of eating disorders (Mangweth-Matzek et al., 2014). Mangweth-Matzek et al. (2014) found that this biological transition could conceptually resemble puberty. Both stages are during times of major hormonal and psychological change, and both could represent parallel windows of opportunities for eating disorders (Mangweth-Matzek et al., 2014).

There is a risk of under assessment and lack of treatment from clinicians for middle-aged adults with eating disorders (Harris & Cumella, 2006). This could be due to the fact that middle-aged adults may be embarrassed for having a "teenage" pathology or

are not assessed for eating disorder symptomatology (Forman & Davis, 2005; Harris & Cumella, 2006; Luca et al., 2015) Furthermore, age of onset is irrelevant if the eating disorder continued beyond adolescence and young adulthood, because the eating disorder becomes a present concern in middle-aged adults (Luca et al., 2015; Midlarsky & Nitzburg, 2008). This is significant because a middle-aged woman with an eating disorder is at risk for increased physiological distress and death (Luca et al., 2015). Luca et al. (2015) even found some authors suggesting that an eating disorder has the same meaning as indirect suicide. For example, a middle-aged woman's end goal for engaging in self-starvation is not death, but the action could result in death (Harris & Cumella, 2006).

There is a substantial amount of verbal treatment literature about working with middle-aged adults with eating disorders (Chen et al., 2015; Dare, Eisler, Russel, Treasure, & Dodge, 2001; Fairburn et al., 2013; Forman & Davis, 2005). Dare, Eisler, Russell, Treasure, and Dodge (2001) did a randomized controlled trial of family therapy, psychodynamic psychotherapy, and cognitive analytic therapy and compared them to routine treatment, which was outpatient management therapy sessions by psychiatrists in training. They found that psychodynamic psychotherapy and family therapy was more effective in producing weight gain than routine treatment. They also found that all three psychotherapies were more effective than routine treatment. Forman and Davis (2005) found that middle-aged women in their in-patient unit were overall satisfied with the residential group programming as much as the young adult and adolescent patients, and that they experienced significant relief from their symptoms.

There is a sizable amount of treatment and research literature concerning children, adolescents, and young adults aged eighteen to thirty-five with eating disorders (Harris & Cumella, 2006; Herpertz-Dahlmann, 2015; Isomaa, Isomaa, Marttunen, Kaltiala-Heino, & Björkqvist, 2009; Smink, van Hoeken, Oldehinkel, & Hoek, 2014). One study found that eating disorders are the third most common chronic illness among adolescents (Smink et al., 2014). In a Finnish study executed over three years, Isomaa, Isomaa, Marttunen, Kaltiala-Heino, and Björkqvist (2009) found that the prevalence was 12% for eighteen-year-old females.

The music therapy literature on eating disorders focuses mainly on children, adolescents, and young adults (Dokter, 1995; Hilliard, 2001; Lejonclou & Trondalen, 2009; McFerran, Baker, Patton, & Sawyer, 2006; Nolan, 1989; Robarts & Alboda, 1994; Trondalen, 2003; Trondalen & Skårderud, 2007; Yinger & Gooding, 2014). Two sources briefly discussed music therapy treatment with adults forty years or older (Dokter, 1995; Hilliard, 2001), but did not expand upon their music therapy treatment program and outcomes. Middle-aged adults with eating disorders may not be receiving the benefits of music therapy treatment due to the idea that it is a "teenage" pathology. With the growing body of verbal treatment literature focusing on middle-aged adults, there is an observable gap in the literature concerning music therapy treatment methods with middle-aged adults with eating disorders.

The purpose of this critical review of the literature is to examine the verbal and music therapy treatment literature with children, adolescents and young adults compared to verbal treatment literature of middle-aged adults in order to recommend music therapy treatment methods for middle-aged adults with eating disorders.

**Operational Definitions**

- **Eating Disorders**- distorted eating or eating-related behaviors that modify food consumption, and impair health or psychosocial functioning. This thesis will focus on **Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder**
- **Middle-Aged Adults**- People aged between forty to sixty years old
- **Music Therapy**- Use of clinical and evidenced-based music interventions to accomplish individual and group goals through a therapeutic relationship by a credentialed professional (American Music Therapy Association, 2016).
- **Verbal Treatment Literature**- Treatment that utilizes predominantly verbal interventions
- **Emotional Dysregulation**- A person's inability to regulate or control their emotional responses to emotional stimuli

In this critical review of the literature, this writer examined research and case study materials relating to adolescents, young adults aged eighteen to thirty-five, and middle-aged adults with eating disorders. Upon synthesizing the literature from various perspectives, this writer makes recommendations for music therapy practices with middle-aged adults with eating disorders. This writer is aware of middle-aged men and women with eating disorders, but a majority of the verbal treatment literature focused on middle-aged women.

# CHAPTER 2: LITERAUTRE REVIEW

## Eating Disorders

Eating disorders (ED) are described in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 as disordered eating or eating-related behaviors that modify food consumption, and impair health or psychosocial functioning (American Psychiatric Association (APA), 2013). It can cause significant damage to growth, physicality and mental health, and sometimes can prove fatal (National Collaborating Centre for Mental Health (NCCMH), 2015). The most common eating disorders are anorexia nervosa (AN), bulimia nervosa (BN) and binge eating disorder (BED) (Castro-Fornieles, 2015; Mancuso et al., 2015; Smink et al, 2014). Eating disorders typically begin in adolescence or early adulthood (APA, 2013; Castro-Fornieles, 2015). According to Castro-Fornieles (2015) lifetime prevalence rates in women for AN, BN, and BED are 1%, 2% and 3.5% respectively. With the shift from the DSM-IV-TR to the DSM-5, Mancuso et al. (2015) found that there was an increase in anorexia diagnoses from 33% to 41% and an increase in bulimia nervosa diagnoses from 27% to 33%, and a 6% prevalence for binge eating disorder. Smink et al. (2014) found that eating disorders were the third most common chronic illness among adolescents. Among their sample of female and male adolescents, the most common diagnosis among women was BED and AN. Among men the most common diagnosis was BED (Smink et al., 2014).

The etiology of eating disorders can be influenced by several social, cultural, psychological, and genetic factors (Castro-Fornieles, 2015). One of the most prominent is the sociocultural idealization of thinness and youth, creating almost a cult of thinness (Culbert, Racine, & Klump, 2015; Fikkan, 2010; Kadish, 2012; Kinsaul, Curtin, Bazzini,

& Martz, 2013; Levitt, 2004; Slevec & Tiggemann, 2011). Kadish (2012) explained that cultural factors of fat and thin provided a set of meanings that regulates eating disorder pathology.

Anita (1996) discussed the influences of society on women in a patriarchal sense. She researched the experience of women back to the time of goddesses, and how the spirit of femininity was recognized as a creative life force. It was symbolized at the time as a circle, with no beginning and end. A round or curve was considered beautiful as it represented the shape of the earth, and things that moved in cycles were honored as a source of wisdom. As time passed, the world began to perceive the line as superior to a circle, which had a beginning and an end, and the goddess was banished for the male God (Anita, 1996). A woman's connection to the wisdom of the earth through her body was rejected, and the power of her intuition and emotions were ridiculed. Because of this banished feminine spirit, women tend to live in a state of perpetual spiritual hunger without nourishment of the Goddess. The only thing left is the food she feeds herself with, so is it no wonder that women overcompensate for their spiritual starvation by going on strike and not eating. Food becomes a source of control for a woman's power over the male society she lives in (Anita, 1996).

Kadish (2012) presented a case study of an individual girl in her thirties with AN. Kadish (2012) found that the girl's distress and ED were influenced by her cultural beliefs about what weight for women should be at her age. Kadish (2012) hypothesized that the patient's ED operated as both a compliance and resistance to her socio-cultural environment. The girl used her weight as a way to identify with her culture, and at the same time resist it through controlling what she ate and how much (Kadish, 2012).

Fikkan (2010) suggested that self-expression is often combined with a range of body management practices. For example, a woman's control of her eating to achieve thinness is a way of expressing her identity (Fikkan, 2010). In addition, Castro-Fornieles (2015) found that psychological aspects such as low self-esteem, high perfectionism and impulsiveness might also be relevant to the etiology of eating disorders. Adverse experiences that could increase vulnerability to develop an eating disorder include school, family, or social, physical, emotional, or sexual abuse (Castro-Fornieles, 2015).

Slevec and Tiggeman (2011) found that body dissatisfaction is commonly reported among middle-aged women and it is associated with disordered eating, and maladaptive attitudes and behaviors. Body dissatisfaction and disordered eating were grouped into three categories: biological, psychological and sociocultural (Gagne et al., 2012; Slevec & Tiggeman, 2011). Biological factors included one's body mass index (BMI) and menopausal status; psychological factors included aging anxiety, negative affect, perfectionism and self-esteem; and sociocultural factors included perceived pressure from family, peers, and the media, as well as race-ethnicity pressures and sexual or physical abuse (Slevec & Tiggeman, 2011). Aging anxiety in combination with the belief that a thin body is associated with youthful looks can drive middle-aged women to engage in unhealthy methods of weight control (Slevec & Tiggeman, 2011). Slevec and Tiggeman (2011) found that many factors associated with body dissatisfaction and disordered eating in middle-aged women were similar to adolescents, but middle-aged women also go through typical age-related changes, such as wrinkles or liver spots. The biggest biological milestone of midlife associated with negative views on appearance-

related changes in middle-aged women was menopause (Mangweth-Matzek et al., 2014; Slevec & Tiggeman, 2011).

**Anorexia Nervosa.**

Anorexia Nervosa (AN) is defined in the DSM-5 as the restriction of food intake with intense fear of weight gain, and distortion in self-perceived weight (APA, 2013). A person experiencing AN has a body weight that is below normal for age, sex, development, and physical health. The lack of nutrition can cause a variety of physical disturbances, and it affects major organ systems. Some people diagnosed with AN tend to show signs of depression, social withdrawal, irritability, insomnia, and diminished sex drive (APA, 2013). People with AN are often diagnosed with other psychiatric co-morbidities including major depression or dysthymia, anxiety, and obsessive-compulsive disorder (Yager & Andersen, 2005). Additionally, there can be a loss of fat tissue, hypotension (abnormally low blood pressure), impaired menstrual function, hair loss and hypothermia (abnormally low body temperature) (Kinoy, 2001; Yager & Andersen, 2005). When a person with AN is severely underweight, it can lead to medical complications and hospitalization (Kinoy, 2001). When a person with AN is in a starved state, it leads to a volume reduction of gray and white matter in the brain (Herpertz-Dahlmann, 2015). Gray matter regions of the brain are involved with muscle control and sensory perception, such as emotions, speech, decision-making, and self-control (Herpretz-Dahlmann, 2015). White matter regions of the brain assist in rapidly passing messages between different areas of gray matter (Herpertz-Dahlmann, 2015).

Botha (2015) researched the current psycho-medical constructs of AN, and found that it is acknowledged among the research as highly complex. The medical model

undercuts this complexity, although it has been embraced by both psychiatry and psychology (Botha, 2015). As a result, much of the research has been focused within the medical model rather than focusing on the complexity of AN (Botha, 2015). Regardless of the complexities and risk factors for AN, it is understood by the medical establishment an "internalized, psychomedical feminine phenomenon" (Botha, 2015, p. 330) and a person with AN becomes pathologized (Botha, 2015). Lavender et al. (2015) found in their literature review that individuals with AN demonstrated high levels of emotional dysregulation, greater difficulties with behavioral control during times of emotional stress, and difficulties in being aware of and recognizing different emotional states.

**Bulimia Nervosa.**

Bulimia Nervosa (BN) is defined by the DSM-5 as consisting of frequent cycles of binging and purging with an obsession over body image and weight accompanied by feeling out of control (APA, 2013). Some of the ways people with bulimia prevent weight gain include purging, fasting, excessive use of laxatives, and excessive exercise (APA, 2013). This can cause various, internal physical damage similar to that of AN (Kinoy, 2001). BN can impact the gastrointestinal system, cause esophageal tears, reflux, and decreases potassium which can cause muscle weakness and lead to respiratory arrest or irregular heart rhythms (Kinoy, 2001). It can also cause irregular menstrual periods, no bowel functions, and increased infertility if not managed. Kinoy (2001) found that up to 20% of women with bulimia abuse drugs or alcohol, and hospital treatment might be needed.

Lavender et al. (2015) found that the literature suggests the idea that those with BN report difficulties with emotional regulation. In addition, they found that those with

BN demonstrated decreased behavioral control during times of distress, decreased emotional awareness, and higher reward sensitivity and/or novelty seeking (Lavender et al., 2015). They also found that there is not a significant difference in these emotional dysfunctions compared to AN.

**Binge Eating Disorder.**

Binge Eating Disorder (BED) is defined by the DSM-5 as recurring episodes of binge eating that have to occur at least once per week for 3 months (APA, 2013). Binge eating is defined as eating more food than most would eat in a similar setting within a discrete period of time. Binge eating is not limited to context, as an individual could begin eating in a restaurant and then continue eating at home (APA, 2013). This excessive amount of food has to be accompanied by a personal sense of lack of control (APA, 2013). According to Herperzt-Dahlmann (2015), those with BED may use bingeing as a reward or to regulate emotions. BED often begins in adolescence, but is sometimes present in children (Herpertz-Dahlmann, 2015). Individuals tend to present high psychiatric comorbidities, specifically mood and anxiety disorders (Herpertz-Dahlmann, 2015).

## Treatment Approaches

Since there is a paucity of literature about middle-aged adults with ED, this writer examined treatment approaches with adolescents and young adults in order to better inform music therapy treatment approaches. There are numerous treatment approaches that have been researched in regard to treatment of adolescents and young adults with ED. This literature review will focus on cognitive behavior therapy, family therapy, and

psychodynamic psychotherapy. The creative art therapies (CATs) will be reviewed in a later section. Two articles from the research discussed inpatient treatment informed by these approaches (Carter et al., 2009; Grave, Calugi, El Ghoch, Conti, & Fairburn, 2014). Some goals of these treatment approaches were to promote weight gain and healthy eating, reduce ED related symptoms and to promote psychological recovery (National Collaborating Centre for Mental Health (NCCMH), 2004).

**Cognitive Behavior Therapy (CBT) and ED.**

According to Farmer and Chapman (2008), CBT is a broad concept that represents numerous therapeutic approaches for the advancement of realistic, accurate and balanced thinking, and a change in thought process that produces changes in mood and behavior. The foundation of CBT is that dysfunctional thinking influences mood and behavior, and treatment approach focuses on changing these cognitive distortions and core beliefs unique to each disorder (Farmer & Chapman, 2008). Waller (2005) found it to be the most studied psychological treatment for EDs, with trials showing that 40-50% of the patients recover from their disorder after several years.

Galsworthy-Francis and Allan (2012) did a systematic review of the literature available on CBT for AN. All randomized controlled trials (RCT) demonstrated an increase of BMI following CBT, and studies suggested some improvement of disordered eating symptoms following CBT interventions (Galsworthy-Francis & Allan, 2012). The general theme of the RCTs results suggested that CBT led to some positive changes in disordered eating (Galsworthy-Francis & Allan, 2012). In the non-RCTs, Galsworthy-Francis and Allan (2012) found a significant increase in BMI over time with both treatment groups showing reduced eating disorder symptoms. Over time, the CBT group

displayed better overall outcomes, and they showed a significant reduction in depressive symptoms (Galsworthy-Francis & Allan, 2012).

Grave, Calugi, El Ghoch, Conti, and Fairburn (2014) assessed the effectiveness of Enhanced CBT (CBT-E), which is CBT used with a variety of new strategies aiming to improve clinical outcomes through treating eating disorder psychopathology rather than only the diagnosis (Murphy, Straebler, Cooper, & Fairburn, 2010), with inpatient adolescents with AN. According to Murphy, Straebler, Cooper, and Fairburn (2010), CBT-E includes modules that address challenges to change that are outside of the core ED, for example low self-esteem. Treatment was separated into three phases; helping patients change their view on their current state, pros and cons of fighting their eating disorders, and helping them regain weight while addressing the difficulties of maintaining an eating disorder (Grave et al., 2014). Parents of participants also received a parents-only session in the first week of treatment to assess the family environment and educate parents (Grave et al., 2014).

Grave et al.'s (2014) results showed there was a substantial increase in weight, and almost 40% of the patients had minimal residual eating disorder psychopathology. In the sixty-week follow-up, the changes made in the hospital were overall maintained (Grave et al., 2014). Grave et al. (2014) concluded that their study findings suggested that inpatient CBT-E could be a possible treatment for adolescents diagnosed with severe AN. In another study, Carter et al. (2009) compared individual CBT to maintenance treatment as usual (MTAU) in an inpatient setting. The MTAU intervention consisted of encouraging patients to seek follow-up care naturally, but they had the choice not to attend after-care therapy (Carter et al., 2009). The aim of their study was to compare the

frequency and timing of relapse in adolescent patients with AN (Carter et al., 2009). Their results indicated that it took longer for the patients in the CBT condition to have a relapse compared to the MTAU group (Carter et al., 2009).

Van den Eynde and Schmidt (2008) described a specific type of CBT that focuses on addressing bulimic behaviors and cognitions. It was found that at the end of treatment 30-40% of the patients was symptom free (Van den Eynde & Schmidt, 2008). Latner and Wilson (2000) discussed the use of manual-based (outlined and detailed steps for treatment) CBT for BN and BED, which was designed to overcome three forms of dysfunctional dieting. The course of treatment for BN was sequenced to develop a regular, more normal pattern of eating. The strategies they used incorporate making major changes to eating behavior including self-monitoring, education, self-control strategies, and alternative behavior to binge eating (Latner & Wilson, 2000). Wilson (1998) described manual-based CBT as the treatment with the most empirical support as it is designed to restore a flexible, regular pattern of eating. Waller (2005) also found that CBT clinical research trials showed that 40-50% of their patients recovered from their disorder, and a greater number of patients demonstrated a significant reduction of symptoms.

Anderson and Maloney (2001) reviewed the efficacy of CBT on five core symptoms of BN that they presented as neglected in previous reviews. The five core symptoms as defined by the CBT model included low self-esteem, extreme concerns about shape and weight, strict dieting, binge-eating, and self-induced vomiting (Anderson & Maloney, 2001). In their review, Anderson and Maloney (2001) found that few single studies assessed all five of the core symptoms, and most focused on binge eating and

purging behaviors. Thompson-Brenner, Shingleton, Sauer-Zavala, Richards, and Pratt (2014) observed in their study that a 25% reduction in the Beck Depression inventory score appeared to be a better predictor of long lasting remission than 65% reduction in purging. Similarly, Agüera et al. (2012) evaluated the changes in personality traits in outpatients with BN after CBT. Agüera et al. (2012) found that there was a significant symptom reduction for eating and general psychopathology, and it was useful in some temperamental personality traits such as harm avoidance and reward dependency. Their findings also indicated a positive association between personality changes and clinical improvement (Agüera et al., 2012).

Fischer, Meyer, Dremmel, Schlup, and Munsch (2014) evaluated the long-term efficacy following short-term CBT for BED four years after treatment. Characteristics they reviewed were frequency of binges, eating disorder pathology, and depressive symptoms. Their results showed that there was a strong improvement of BED core symptoms during the treatment phase, and a less than strong improvement in the follow-up period (Fischer et al., 2014). In terms of BED symptoms, they found that all the core symptoms decreased, and eating, shape and weight concerns further improved during the follow-up study (Fischer et al., 2014).

**Family Therapy and ED.**

Family therapy focuses on the family as the context for understanding individual functioning. This concept incorporates systems theory, which explains that one part of the system cannot be understood without knowing the other parts, into the study of family (Goldenberg & Goldenberg, 2012). The family relational view directs the attention externally on the interaction patterns occurring presently within the family, rather than

attempting to discover why a behavior occurs due to something that happened in a patient's past (Goldenberg & Goldenberg, 2012).

Family-based treatment has developed into the most significant treatment for medically stable adolescent patients with ED (Murray & Grange, 2014). According to Murray and Grange (2014), family-based treatment boasts that parents have the necessary skills and resources to help their child, but become anxious in the presence of AN. Empirically speaking, Murray and Grange (2014) found in their literature review that between 50-75% of patients has a typical weight restoration within twelve months of finishing treatment. In addition, they found that perceived self-efficacy was a predictor of adolescent outcomes throughout treatment. Family-based treatment has also been adapted to adolescents with BN, which is theoretically similar to family-based treatment for AN. The difference is that the aim of the parent is to help re-establish stable patterns of eating, and to take a more collaborative stance where parents and adolescents can discuss and establish therapeutic goals (Murray & Grange, 2014). Schmidt et al. (2007) found in their study that within family therapy, adolescents with BN demonstrated a substantial decrease in binging behaviors between total treatment time and at six-month follow-up.

Stewart, Voulgari, Eisler, Hunt, and Simic (2015) reviewed multi-family treatment (MFT) for BN in adolescence. BN can place stress on the family, and the family can experience practical, emotional and relational difficulties (Stewart, Voulgari, Eisler, Hunt, & Simic, 2015). Due to the difficulties of motivating adolescents to engage in therapy with their parents, the MFT-BN's structure provides the first two sessions individually (Stewart et al., 2015). The treatment approach includes CBT elements, such as psychoeducation. The adolescent is encouraged to regain control, and from there the

family negotiates how to provide the best support (Stewart et al., 2015). Forsberg and Lock (2015) also suggested that family therapy treatment approaches be adjusted for adolescents with BN. The therapist is in a consultative role through psychoeducation of responsibilities for their actions, and helps to alleviate family guilt and shame (Forsberg & Lock, 2015). Adolescents with BN are acknowledged within family therapy treatment for having increased independence, and parental collaboration is different than with AN (Forsberg & Lock, 2015). The participants guided the development of the program over the course of five years. It indicated that the program has allowed families to incorporate new ways of coping with BN and to communicate with each other. Overall, the families found the program beneficial (Stewart et al., 2015)

Marzola et al. (2015) evaluated the effect of intensive family therapy (IFT) retrospectively for adolescents with eating disorders. One hundred and eighteen families participated in both single and multiple IFT short-term sessions. Marzola et al. (2015) found that there was significant weight and behavioral symptom remission. Gelin, Fuso, Hendrick, Cook-Darzens, and Simon (2015) also examined multi-family therapy with adolescents with eating disorders. Weight remained within a clinical range and this appeared to be accelerated through the relationship-focused phase (Gelin, Fuso, Hendrick, Cook-Darzens, & Simon, 2015). Their patients also showed significant changes on all dimensions, and quality of life had significant improvements in reduction of anxiety, affective and adjustment disorders, and stress related illnesses (Gelin et al., 2015).

This author found limited articles addressing family therapy with BED. Dancyger, Krakower, and Fornari's (2013) discussion of family therapy with EDs focused primarily

with adolescents with AN. Braden et al. (2014) discussed parent binge eating and depressive symptoms as reasons for attrition in family therapy for pediatric obesity. Their results showed that parent binge eating was related to drop out in childhood obesity treatment, as they do not model healthy eating habits for their children (Braden et al., 2014).

**Psychodynamic Psychotherapy with ED.**

In psychodynamic psychotherapy, past issues are recalled and explored (Penny, 2005). It incorporates many theoretical models including Freud and conflict theory, ego psychology, self-psychology, object relations, family systems theory, attachment theory, feminist theory, relational theory, trauma theory, and intersubjectivity (Toto-Moriarty, 2012). It was developed to bring about empowerment by understanding the patient's experience of the therapist, and for the therapist to understand his or her own emotional reactions to the patient (Murphy, Russell, & Waller, 2005).

Murphy, Russell, and Waller (2005) found that within psychodynamic psychotherapy with patients experiencing ED, it is useful to integrate behavioral principles, and have time-limited interventions. They found that the combination of the two therapeutic approaches demonstrates the importance between addressing the interpersonal process and more active behavioral interventions (Murphy et al., 2005). The authors studied this adapted psychodynamic psychotherapy with twenty-one female patients diagnosed with BN or BED. Their results showed that the frequency of bulimic behaviors fell significantly during treatment for both groups, and rate of improvement was maintained at follow up (Murphy et al., 2005). In addition, they found that the

majority of the patients who completed treatment appeared to become free of behavioral symptoms (Murphy et al., 2005).

Dancyger, Krakower, and Fornari (2013) reviewed treatment studies of psychodynamically informed psychotherapy for eating disorder in adolescents. Their research demonstrated that patients receiving individualized psychotherapy treatment had the same rate of remission at one-year-follow up as CBT (Dancyger, Krakower, & Fornari, 2013). Toto-Moriarty (2012) researched a retrospective view of psychodynamic treatment for BN patients. They found that the initial development of trust with the therapist assisted with therapy (Toto-Moriarty, 2012). From there the participants reported progress on four major themes: family preoccupation with food, past traumatic experiences, bulimia as a coping mechanism, and triggers related to the symptom (Toto-Moriarty, 2012). Toto-Moriarty (2012) explains that the six emergent themes that demonstrated signs of progress were: developed insight and capacity to self-reflect, demystification of food, positive experiences, shift to a more positive and realistic body image and self-image, and a more realistic and empathic view of others.

Pouslen et al. (2014) researched and compared psychoanalytic psychotherapy and cognitive behavioral therapy in the treatment of BN in Denmark. Psychoanalytic psychotherapy explores unconscious thoughts and feelings, which might underlie the presenting difficulties (American Psychoanalytic Association, 2015). CBT was found to be more efficacious in reducing binging and purging in a larger percentage of patients within twenty-four months than psychoanalytic psychotherapy in treatment. However, Pouslen et al.'s (2014) research found that psychotherapy addressed global eating

disorder psychopathology, and directive and behavioral interventions were needed to affect binge eating and purging behaviors.

Poulsen, Lunn, and Sandros (2010) interviewed fourteen clients' experiences with BN receiving individual psychodynamic psychotherapy. Although the clients stated not discussing the eating disorder during therapy, they expressed that they gained "a lot from the therapy" (Poulsen, Lunn, & Sandros, 2010, p. 476). In terms of bulimic symptoms, most of the clients expressed having fewer binges, thoughts about food and being fat, and more acceptances of their weight and a better feeling about their body (Poulsen et al., 2010). The clients expressed handling and understanding their BN in a new way, with some revealing their ED to family members or friends, a decreased preoccupation with food, and a more "conscious awareness of experiences in their inner or outer life that could stimulate a binge" (Poulsen et al., 2010, p. 477). The central gain from the therapy was that all clients but one expressed recognitions of their emotions to a much larger extent and experienced themselves as more assertive (Poulsen et al., 2010).

Rolland (2006) provided a case study on his work within individual psychoanalytic in-patient psychiatric treatment with a twenty-five year-old woman with AN. Throughout most of the session Rolland (2006) discusses transference forces from the patient for the need to control the session and the therapist, actualization, and the therapist helping the patient connect her unconscious and preconscious forces. The major change in the session was that the patient released her transference of the mother object from the therapist onto her boyfriend, changing the perspective and power of the therapeutic relationship. This relates to ED as most often patients with AN have a

romanticized view of the relationship with the mother, and decrease the significance of the father (Lawrence, 2001).

Tasca, Balfour, Presniak, and Bissada (2012) assessed group psychodynamic interpersonal psychotherapy compared to group CBT on outcomes to specific interpersonal problems associated with BED. Specific interpersonal problems were measured by the Inventory of Interpersonal Problems (IIP), which assessed overall distress regarding interpersonal problems (Tasca, Balfour, Presniak, & Bissada, 2012). The group psychodynamic interpersonal psychotherapy focused on relationship patterns (Tasca et al., 2012). Both treatments facilitated clinically meaningful change in total interpersonal distress in a substantial percentage of individuals with BED (Tasca et al., 2012). Tasca et al. (2012) found that group psychodynamic interpersonal psychotherapy had a greater effect on the interpersonal problem area that might underlie emotional sensitivity and maladaptive coping.

**Treatment Approaches with Middle-Aged Adults**

There is an increase in the literature on treatment approaches used with adults with eating disorders. A majority of the literature focused on CBT with adults with EDs (Carter et al., 2011; Darcy, Fitzpatrick, & Lock, 2015; Devlin, Goldfein, Petkova, Liu, & Walsh, 2006; Fairburn et al., 2012; McLean, Paxton, & Wertheim, 2011; Murphy et al., 2010; Pisetsky et al., 2015; Ricca, Castellini, Sauro, Rotella, & Faravell, 2009; Waller et al., 2014). An important factor in treatment approaches with adults that can differ from adolescent patients is the duration of the eating disorder and the patient's developmental stage (Doyle, Smyth, & Le Grange, 2012). Adults tend to have had a longer duration of

illness and report battling their symptoms for longer (Ballard & Crane, 2014; Doyle et al., 2012). Doyle, Smyth, and Le Grange (2012) state that these factors cause the ED to affect more aspects of a middle-aged adult patients life, and change can be difficult with long-standing behaviors. Ballard and Crane (2014) also stated that undetected long-standing EDs in adults become a part of their identity, and they are less likely to accept programs geared towards adolescents.

**CBT with Adults.**

Murphy et al. (2010) reviewed the evidence supporting CBT in the treatment of middle-aged adults and adolescents with eating disorders. In their review they discovered that the conclusion of a meta-analysis conducted by the UK National Institute for Health and Clinical Excellence (NICE) found that CBT was the leading treatment for BN in middle-aged adults. Murphy et al. (2010) had difficulty finding research treatment of AN for middle-aged adults. They cited that preliminary findings from a three-site study found that CBT was used to treat about 60% of outpatients, and of those, 60% had a good outcome. With BED, Murphy et al. (2010) found that CBT treatment had a sustained effect on binge eating, but had little effect on body weight.

Fairburn et al. (2012) researched the use of enhanced CBT on middle-aged adults with AN. Ninety-nine primarily single, female patients were recruited from both the UK and Italy, and had a diagnosis of AN with a BMI of 17.5 or below. Participants received forty sessions of treatment over forty weeks, and only received psychological interventions (Fairburn et al., 2012). They received CBT-E interventions that began by increasing patients' motivation to change, helping patients regain weight while tackling their eating disorder psychopathology, and then helping the patients develop personalized

strategies for identifying and correcting any setbacks (Fairburn et al., 2012). Patients who completed the CBT-E program had a BMI increase of 2.77, and over sixty percent achieved a BMI that was greater to or equal 18.5, which is a healthy BMI for patients. In addition, a majority of the patients maintained the BMI increase in the sixty week follow up.

McLean, Paxton, and Wertheim (2011) evaluated a CBT-based intervention on body dissatisfaction and disordered eating in midlife. Their intervention program was CBT based with themes of age-related appearance changes, engagement in self-care, body acceptance, and self-worth within the context of midlife (Mclean, Paxton, & Wertheim, 2011). Throughout the study, participants completed self-report surveys related to the different variables pre- and post-test. Participants in the intervention group showed a significant improvement from baseline to posttest compared to the control group (McLean et al., 2011). In addition, the effects were maintained at the six-month follow-up. McLean et al. (2011) concluded that improvements in the intervention group reflected clinically meaningful change. McLean et al. (2011) also found that focusing on circumstances of midlife resulted in the analysis of important situations that could trigger eating concerns.

Pisetsky et al. (2015) researched the effect of group CBT (gCBT) on treatment outcomes with adults with BED at the end of treatment, and at six and twelve months follow up. They defined treatment outcomes as reduced post-treatment disordered eating and treatment retention. Pisetsky et al. (2015) found that stronger group engagement in gCBT was associated with greater improvements at twelve-month follow up, and a greater reduction in binge eating frequency. Fischer, Meyer, Dremmel, Schlup, and

Munsch (2014) examined the effect of short-term CBT for BED to evaluate the long-term efficacy of the treatment during a four-year follow-up. ED pathology was assessed with the self-report version of the eating disorder examination at the end of treatment and repeatedly for three, six, twelve months and four-year follow up (Fischer, Meyer, Dremmel, Schlup, & Munsch, 2014). Sessions of treatment included identifying triggers of binge eating and development of individual coping strategies. Fischer et al. (2014) found that there was a strong improvement of BED core symptoms during treatment, and followed by a less strong improvement in the follow-up period. They concluded that the probability of a BED diagnosis decreased and abstinence increased during treatment, and improved slightly in the follow-up. In terms of eating pathology, Fischer et al. (2014) found that over the follow-up period, eating, shape, and weight concern improved. Munsch, Meyer, and Biedert (2012) researched the long-term efficacy of CBT on patients with BED in a six-year follow-up. They found that binge eating frequency and ED pathology improved during active treatment, and were still improved at six-year follow up compared to pre-treatment measures.

Waller et al. (2014) reviewed the effectiveness of CBT with adults with BN in an outpatient ED program. CBT treatment consisted of individualized formulation, agenda setting, homework, and change in diet, cognitive restructuring, and surveys (Waller et al., 2014). All patients received individual CBT. Their results showed that there was an abstinence rate at the end of treatment of 82% in laxative abuse, 58% in binging, and 51% in vomiting (Waller et al., 2014). In addition, there was a significant reduction in frequency of behaviors, negative eating attitudes and depression (Waller et al., 2014). Lockwood, Serpell, and Waller (2012) assessed outpatient CBT for middle-aged adults

with AN. Their treatment focused on change in diet with the aim of weight gain, early emphasis on psychoeducation, motivation, dietary change, cognitive restructuring, exposure, and behavioral experiments to address central beliefs (Lockwood, Serpell, & Waller, 2012). Over the course of the ten sessions, weight increased and the researchers did not find a correlation between BMI increase and age. However, they did state that older participants gained the least amount of weight. Lockwood et al. (2012) concluded that all participants who completed the ten sessions gained weight compatible with achieving a functional weight over a longer CBT treatment.

Carter et al. (2011) evaluated the long-term efficacy of three psychotherapies for AN, including CBT. The treatment was based on the understanding of the core features of AN: food restriction and avoidance. Participants were invited to attend this long-term follow-up assessment for five years following treatment. Participants who were randomized into CBT had a more stable post-treatment and long-term follow-up improvement (Pouslen et al., 2014). Poulsen et al. (2014) compared psychoanalytic psychotherapy to CBT for the treatment of BN. Their results indicated that CBT was more effective in treating core bulimic symptoms. Pouslen et al. (2014) found that 42% of patients did not have binging and purging behaviors at the end of treatment, and 44% after twenty-four months. In addition, there was a more rapid change in the CBT condition for general ED pathology.

Darcy, Fitzpatrick, and Lock (2015) provided cognitive remediation therapy (CRT) as a precursor to CBT. CRT provides patients the opportunity to explore and practice specific cognitive exercises to improve neurocognitive functioning. Darcy et al., (2015) provided this treatment to Linda, a fifty year old participant with a long-standing

history of AN, who first sought treatment at the age of thirty-nine. After five sessions, Linda transitioned to CBT and brought with her a sense of curiosity about tasks and homework (Darcy, Fitzpatrick, & Lock, 2015). Throughout the course of treatment Linda had a significant increase in weight and enhancement of CBT treatment through a collaborative therapeutic relationship and promotion of change (Darcy et al., 2015).

Two articles researched the effect of CBT in conjunction with pharmacotherapy in the treatment of middle-aged adults with BED (Devlin et al., 2006; Ricca et al., 2009). Delvin et al. (2006) researched and compared the effectiveness of CBT and fluoxetine (an antidepressant medication) in a two-year follow-up. Overall, they found that there was a substantial improvement in binge eating behaviors with slight continued improvement over two years. In addition, Devlin et al. (2006) found that treatment had an effect on self-reported measures relating to mood, eating, body image, and general psychopathology. Devlin et al. (2006) found that individual CBT had longer lasting effects on BED symptoms, and there was no benefit of fluoxetine on binge eating. Ricca et al. (2009) researched the effectiveness of CBT combined with zoniasmide (an anti-seizure medication) in patients with BED. At the end, the CBT group with zoniasmide demonstrated a more significant increase in BMI, eating disorder examination questionnaire, Beck Depression Inventory, and binge eating. Ricca et al. (2009) also found that the results were maintained one year after the study.

**Couple and Family Therapy.**

Within the treatment literature, this author found limited studies on the use of family therapy for middle-aged adults (Dimitropoulos, Farquha, Freeman, Colton, & Olmsted, 2015). Due to the nature of family therapy being parental control over ED

symptom profile, it makes family therapy more directed towards adolescents (Murray, 2014). To adapt, the research integrated a family based approach through couple therapy in the treatment of adults with EDs. In this treatment approach, couples are integrated in the therapy to help the partner understand how the ED influences the relationship, exploring each partner's experience, and teaching effective communication skills to problem solve challenges (Murray, 2014).

Dare (1997) describes the use of a systems-based approach for Angela in an outpatient care unit. Through the sessions he found that Angela (the patient) was projecting Sophie (her partner) as capable, and herself as needy due to the ED and suicidal thoughts. Dare (1997) explained that ED can become absorbed into the relationship. Dare (1997) found that the couple's therapy worked to confront the relationship processes that were occurring due to the nature of the relationship, and how the ED was exacerbating the dynamics.

Dimitropoulos, Farquhar, Freeman, Colton, and Olmstead (2015) compared multi-family therapy (MFT) to treatment as usual (single family therapy) to observe if MFT is feasible for middle-aged adults with AN in an intensive ED program. In addition, the researchers were examining to see if MFT would improve outcomes for family members (Dimitropoulos, et al., 2015). MFT is described as a manualized driven treatment approach combining psychoeducation and experiential exercises (Dimitropoulos et al., 2015). To assess the effectiveness of MFT, Dimitropoulos et al. (2015) received qualitative feedback from patients and family members stating the benefit of sharing with others who understood their struggles with AN. In addition, family members experienced improvements on various outcome measures as the patient decreased in ED pathology,

and increased BMI. The results indicated that MFT might be effective in contributing to positive outcomes in families of middle-aged adults with AN receiving intensive treatment (Dimitropoulos et al., 2015).

Linville and Olekask (2013) summarize the existing couples therapy treatments for adults with eating disorders available, and an integrative therapy approach for working with couples. Although they found limited research, some of their literature suggested that a significant amount of adults in treatment for AN were also in committed relationships that were beneficial to their recovery process. Linville and Olekask (2013) describe the importance of understanding ED within couples therapy in the context of attachment theory. They explain that viewing ED through attachment theory expands the issue to the larger systems of relationships. Linville and Olekask (2013) provided an example of a couple seeking couples therapy due to the wife's (Allison) struggle with an ED. Allison's ED was possibly seen as a way to achieve emotional regulation and distraction from painful experiences without asking for help from others. Linville and Olekask (2013) found that the ED had a significant impact on their relationship that led to more ED symptoms. From this, the researchers developed an integrated family therapy treatment approach, and how this approach might be used in a session. The model would work to strengthen attachment of the couples through focusing on the intimacy of the couple, restructure how the couple interacts around food, and help the couples prepare for the challenges of ongoing recovery from the ED (Linville & Olekask, 2013).

Murray (2014) presented a case study of a man named Bernardo diagnosed with severe AN, and was receiving couples therapy. He initially received CBT and demonstrated cognitive insight and development in challenging AN cognitions (Murray,

2014). However, by the end of treatment he did not experience any significant weight gain because he expressed that conflicts with his wife escalated his symptoms (Murray, 2014). The interventions utilized exaggerated the dynamic around AN to a point where the couple was in agreement about rejecting it, and helped the couple interact around food without fixating on AN. After couples therapy had been provided, Bernardo gained weight and increased BMI, which was maintained at six-month follow-up. This demonstrated that this treatment approach can be effective to disrupt the use of AN's symptoms in a marital dyad (Murray, 2014). In addition, this case shows the significance of treating AN in context of an individual's interpersonal relationships (Murray, 2014).

Bulik, Baucom, and Kirby (2012) provides a case study illustrating how AN for adults exists within a social context, and that the AN affects the relationship and the relationship affects the course of AN. Within the course of therapy, patients emphasized the importance of relationships in the recovery process and, in contrast, how difficult relationships can worsen the course of illness (Bulik, Baucom, & Kirby, 2012). From this, Bulik et al. (2012) developed an intervention called uniting couples (in the treatment of) AN (UCAN). Bulik et al. (2012) developed it after finding the potential of a supportive partner in the treatment of AN, but there were reported difficulties in these committed relationships. The focus of the intervention was to help the couple understand their experience of AN, provide psychoeducation about AN and the recovery process, and teach the couple effective communication skills (Bulik et al., 2012; Kirby, Runfola, Fishcer, Baucom, & Bulik, 2015; Murray, 2014).

Kirby, Runfola, Fischer, Baucom, and Bulik (2015) created couple-based interventions that incorporates the partner into the treatment through surveying the

empirical literature supporting the treatment of middle-aged adults in a couple context. They found that couples with eating disorders reported relationship distress, reduced levels of positive interaction, and more negative communication compared to healthy individuals (Kirby et al., 2015). Kirby et al. (2015) explain that many people with AN are emotionally avoidant and struggle to express their feelings, which could negatively impact their ability to articulate their needs, tolerate distress, or remain close. These factors increase the risk for the ED to continue. Kirby et al. (2015) attempted the UCAN model for BED to tackle how weight is discussed in the couple and fundamental misunderstandings regarding the nature of BED. These interventions are currently being researched in pilot studies (Kirby et al., 2015), and the preliminary evidence is promising. These interventions might help to create a supportive environment in maintaining ED recovery for a longer period (Bulik et al., 2012; Kirby et al., 2015; Linville & Olekask, 2013).

**Psychodynamic Psychotherapy.**

The art, dance/movement and music therapy literature that is influenced by psychodynamic psychotherapy will be presented later in the thesis. Gallagher, Tasca, Ritchie, Balfour, and Bissada (2013) researched the effect of attachment anxiety on treatment outcomes in a group psychodynamic interpersonal psychotherapy for women with BED. They measured the relationship between the development of group cohesion with pre- and post-treatment changes in depression, self-esteem, and frequency of binge eating. Gallagher et al. (2013) found that there was a moderate effect on group cohesion, attachment anxiety, and change in treatment outcome measures post-treatment. They found that individuals with high attachment anxiety had a greater decrease in binge eating

when incorporated into a faster rate of group cohesion (Gallagher, Tasca, Ritchie, Balfour, & Bissada, 2013). Gallagher et al. (2013) concluded that growth in a cohesive group environment was an important element for women with BED who had a high need for approval related to attachment anxiety.

Hill et al. (2015) examined the relationship between binge eating and defensive functioning, and that changes in defensive functioning would correlate to change in depression and binge eating episodes through group interpersonal psychodynamic theory. Defensive functioning and attachment levels were assessed pre-test with the attachment styles questionnaire and defense mechanism rating scale. Hill et al. (2015) found that when a person with BED did not utilize secondary defense functions (such as rationalization), binge-eating frequency increased. The reason is that binge eating is a defense to internal conflict. Hill et al. (2015) found that adaptive defensive functioning improved during therapy because of the focus on emotional regulation and improving interpersonal communication. The participants had an increase in the use of higher adaptive defenses, such as self-observation and affiliation (Hill et al., 2015).

Lunn, Poulsen, and Daniel (2015) presented a case of one adult client named Joyce with severe BN and a traumatic background. The therapy was adjusted for Joyce to focus on affects and expression of feelings, attempts to avoid distressing thoughts and feelings, identifications of recurring themes and patterns and connecting these to past experiences (Lunn, Poulsen, & Daniel, 2015). Joyce received psychoanalytic psychotherapy weekly for two years. Lunn et al. (2015) stated that Joyce recovered from her severe bulimic symptoms as a result of the treatment. In addition, her interpersonal problems were significantly reduced, she achieved a deeper understanding of the

consequences of her traumatic experience with her attachment pattern, and she had improved reflective functioning (Lunn et al., 2015).

Dare, Eisler, Russell, Treasure, and Dodge (2001) reviewed the use of psychoanalytic psychotherapy with middle-aged adults with AN. This treatment approach is a time limited and standardized from of psychoanalytic psychotherapy. The therapist addresses conscious and unconscious meanings of the ED symptoms from the patient's history and their family experience, the symptoms affecting the patients relationships, and how those influence the patient's relationship with the therapist as it drives the patient's need to benefit from therapy (Dare, Eisler, Russell, Treasure, & Dodge, 2001). It was compared to 'routine' outpatient treatment. Dare et al. (2001) found psychoanalytic psychotherapy was more effective in producing weight gain than the control treatment.

Dare (1997) described the use of psychoanalytic psychotherapy with an integrative family therapy approach. He presents one case study of a middle-aged patient (Maria) with BN receiving individual psychoanalytic therapy focusing on the effect of the therapist in the room, and helping Maria in evolving a narrative for her life. Dare (1997) explained that Maria had difficulties in relationships, poor self-esteem, and used self-damaging ED symptoms to manage painful affects. Maria's symptoms were a manifestation of her need to control and diminish sexual longings suffered from abuse (Dare, 1997). Dare (1997) found that he was able to connect her adult psychological organization to her childhood experiences through working with Maria's real self.

## Creative Arts Therapy with adolescents with EDs

In order to build a comprehensive understanding of the literature to provide treatment recommendations this writer included other creative arts therapies treatment approaches with eating disorders. The majority of the literature presented is psychodynamically informed, with some CBT (Hilliard, 2001).

### Art Therapy.

This writer found that the common theme within art therapy treatment literature was the use of art as a transitional object that provides concrete expression as a mediator between patient and therapist, and allows the client to see their authentic self through understanding internalized emotional states (Dean, 2013; Fleming, 1989; Luzzatto, 1995; Johnson & Parkinson, 1999; Schaverien, 1995; Waller, 1995).

Johnson and Parkinson (1999) explored the use of art therapy for patients with AN in a group session. The goal of the sessions was to provide a way for the patients to have concrete expression through art materials to move towards symbolization to help explore feelings and relate to others (Johnson & Parkinson, 1999). It was explained that their patients expressed that "intolerable feelings are dealt with by eating" (Johnson & Parkinson, 1999, p. 95). Johnson and Parkinson (1999) explained that through creating paintings the patients allowed themselves to be seen, and were able to express difficult emotions. Through this, the patients progressed from seeing their own feelings in the art work to recognizing and experiencing the feelings within their own bodies (Johnson & Parkinson, 1999). Similarly, Morenoff and Sobol (1989) used art therapy with patients diagnosed with BN towards making change in the internal structure of the self. Through using art as a mediator for the client's intellectual defenses, Morenoff and Sobol (1989)

were able to work on helping their patients reach deeply held issues outside of consciousness or verbal communication.

Luzzatto (1995) explored the images that appeared frequently among her different patients diagnosed with AN. The three sessions she described were with two middle-aged adults and one adolescent. Certain features that were common to the images were the victim, persecution from a bad object, a protective trap, and a no-way out situation (Luzzatto, 1995). All of these images symbolized the experience of the patient with AN. They saw themselves as immature, with outsider aggression and a self-created protection trap, with no escape route (Luzzatto, 1995). Luzzatto (1995) explored these images as a useful therapeutic tool to work with a patient to understand their internal world, how it was projected onto the outside, and decreased their fear when interacting with the external world. The images allowed for the therapist and patient to step outside the paradoxical internal world of a patient with AN (Luzzatto, 1995).

Schaverien (1995) discussed the function of art as a positive transitional object to replace food. Schaverien (1995) reported that food is often understood as way of regulating a patient's internal and external environment. Food is a symptom of the ED, a "means of expressing something else" (Schaverien, 1995, p. 35). Schaverien (1995) proposes that patients with AN interacted with art materials similar to food. Individuals with AN took their time before interacting with the materials, trying to use them in secrecy, or for brief periods at a time. This is similar to the ways that patients with AN might eat small bites of their food, then play around with it (Schaverien, 1995). A patient with BN would binge on the materials and splurge and splash them around the sheet (Schaverien, 1995). Art becomes a way of symbolizing the internal conflict and providing

a possible transitional object (Schaverien, 1995). The art builds a relationship with the self and others, which allows the patient to embody some of the power that had been transferred to food. Eventually, the art becomes the transitional object in place of food (Schaverien, 1995).

Dean (2013) used graphic images where her patients depicted their family as food to help an individual symbolize and explore family dynamics, food preferences and cultural beliefs as they related to food, family and society. The author helped the patients explore their attitudes about food, their family's attitude about food, food rituals, and messages portrayed by the media. Dean (2013) found that the assimilation to Western capitalism or consumerism could cause conflict with the individual's original culture. The combination of an internal cultural conflict with external differences in culture could provide the perfect recipe necessary to trigger an eating disorder.

**Dance/Movement Therapy.**

This writer found that the common theme within dance/movement therapy treatment literature was the use of dance as a method for connecting body and mind to increase interoceptive (relating to the body) awareness, enable emotional expression within a concrete and creative outlet, allow for working through a developmental crises, and build self-esteem (Franks & Fraenkel, 1991; Krantz, 1999; Rice, Hardenbergh, & Hornyak, 1989; Padrão & Coimbra, 2011; Stark, Aronow, & McGeehan, 1989; Totenbier, 1995)

Krantz (1999) discussed the use of insight-oriented Blanche Evan dance/movement therapy with a woman with BN. Krantz (1999) explained that she saw the ED as a cumulative effect of disrupted development of self, body, affect and

relatedness. The Blanche Evan method suggested that by reawakening the body's potential to move, both emotional and mental states could be changed (Krantz, 1999). Within the therapy process the client regained the body as a source of power rather than as a hindrance (Krantz, 1999). One technique used was the reconnection of the client's inner world to the outside, since Krantz (1999) emphasized that women with ED are not conscious of their compulsions. Krantz (1999) goes on to explain that the power of dance can help provide an emotional outlet and psychophysical release. In the case study, Krantz (1999) demonstrated the impact of dance therapy with Elena. Elena was able to resolve her BN through psychophysical integration of working through her trauma, body image distortions and ED symptoms. Overall, the motive for dance therapy was to help patients with ED recognizing their emotions and reconnect them to their behavior and conscious states (Krantz, 1999).

Padrão and Coimbra (2011) tested a pilot study with the use of a dance/movement therapy, body-oriented psychotherapeutic intervention with female patients diagnosed with AN. The author's theory was about interoceptive awareness, where people perceive emotions because we are sensitive to bodily reactions. This was found to decrease in patients diagnosed with AN because the authors assumed it came from the inability to regulate and describe one's emotions (Padrão & Coimbra, 2011). They found that the patient's experience on a body level was uncomfortable and they experienced discomfort with movement or music that induced grounding. This was supported by Rice, Hardenbergh, and Hornyak (1989) who found a patient diagnosed with AN to have rigid, overly controlled, and uncomfortable movements. Over time the patient's movement patterns changed, and they verbalized increased comfort within their body and

willingness to gain weight (Padrão & Coimbra, 2011). In addition, some of the patients began to feel happier emotions when developing increased interoceptive awareness (Padrão & Coimbra, 2011).

Franks and Fraenkel (1991) discussed the use of fairy tales and dance/movement therapy with eating-disordered individuals. Franks and Fraenkel (1991) used these mediums as a way for patients to re-connect with unmet childhood developmental needs of body and mind in a non-threatening and symbolic way. They explained that dance/movement therapy allowed for a re-write of psychological history through embodying their problems using their body and the therapist (Franks & Fraenkel, 1991). At the end of the sessions, the patients had to trust their body's wisdom, and they gained self-insight into the difference between emotional and physical hunger (Franks & Fraenkel, 1991).

Stark, Aronow, and McGeehan (1989) discussed the use of dance/movement therapy with patients diagnosed with BN. The authors explained that patients with BN have difficulty identifying and expressing feelings, and that dance/movement therapy addresses this through improving body awareness, developing a sense of self, recognizing conflicts, and personal strengths (Stark, Aronow, & McGeehan, 1989). Many goals of treatment included body awareness, sense of self, autonomy and self-esteem, interpersonal relationships, and self-expression (Stark et al., 1989). Patients with BN demonstrated their psychological health based on their movements, such as abrupt motions or loss of upper and lower body integration (Stark et al., 1989). Dance/movement therapy allowed for modifying the dysfunctional movement

characteristics to assist in expressing emotions in an appropriate and constructive way (Stark et al., 1989).

**Music Therapy and ED**

This section will focus on music therapy treatment with adolescents with ED to inform treatment recommendations for music therapy with middle-aged adults with ED. Some of the treatment was provided in inpatient settings (Justice, 1994; Lejonclou & Trondalen, 2009; McFerran, Baker, Patton, & Sawyer, 2006; Sloboda, 1995) and others were provided in an outpatient setting (Justice, 1994; Nolan, 1989). The common theoretical approaches in the treatment of EDs were: a focus on developmental theory (Heal & O'Hara, 1993; Lejonclou & Trondalen, 2009; McFerran et al., 2006; Robarts, 1995; Trondalen & Skårderud, 2007; Trondalen, 2003), Winnicott's theory of the "false self" and transitional object (Nolan, 1989; Robarts & Sloboda, 1994; Sloboda, 1995), object relations (Nolan, 1989; Robarts, 1995;Robarts & Sloboda, 1994), and within a humanistic orientation (Yinger & Gooding, 2014).

Heal and O'Hara (1993) provided music therapy treatment to a woman with AN and Down syndrome. Their focus was to help make sense of the patient's emotions and internal world. They used a free-flowing improvisational music therapy technique, called spontaneous sound pictures. The client chose her instrument and the therapists were flexible with the musical interventions (Heal & O'Hara, 1993). The therapists hypothesized that they symbolized the mother in the mother-daughter development period within the music through providing empathy, confrontation and support to develop an identity. Over the course of the sessions the client gained a general acceptance of anxieties and expression through music (Heal & O'Hara, 1993).

Lejonclou and Trondalen (2009) utilized receptive and expressive music therapy with an individual with AN, and another with BN. Their theoretical framework was psychodynamically informed with a focus on developmentally informed psychology. Lejonclou and Trondalen (2009) focused on the sense of self and affect attunement. Relating experiences through music can strengthen the client's inner resources and support a personal journey from shame to confidence through song writing, movement and music, and musical exploration (Lejonclou & Trondalen, 2009). The client with AN gained renewed self-confidence, and the client with BN had a deeper connection between body and mind (Lejonclou & Trondalen, 2009). Lejonclou and Trondalen (2009) explained that they used music therapy approaches to empower the client's strengths, support internal healing resources, and nourish hope of a normal life.

McFerran et al. (2006) did a retrospective qualitative lyric analysis to identify the most commonly described themes in lyrics generated by adolescents with AN. Their treatment approach was song writing through a developmental, psychodynamic theoretical orientation with adolescents with AN in an in-patient setting. The majority of the lyrics related to identity formation with an emphasis on exploring new behaviors. The second most common theme was of relationship dynamics, with the relationship with the mother the most commonly attributed sub-theme (McFerran et al., 2006). In addition, song writing revealed information that had not been previously discussed with other members of the treatment team, and may have brought out material from the subconscious that were more difficult to access (McFerran et al., 2006).

Trondalen and Skårderud (2007) provided music therapy to a twenty-eight year old man with AN. Their theoretical framework focused on mother infant vocal

interactions, developmental psychology, and affect attunement. Affect attunement was described as the clear sharing of inner feeling states (Trondalen & Skårderud, 2007). They worked with the client to regulate his emotional experiences through music, and experience affective intersubjectivity relating to musical and interpersonal aspects (Trondalen & Skårderud, 2007). At the end of the session, the authors found that the man was able to attune to self-directed anger, and used his body to express his inner feelings through the music. The client's use of his body appeared to encourage vitality and the feeling of being alive (Trondalen & Skårderud, 2007). Through this sharing of affects, the client regulated himself emotionally in a way that contributed to a closer connection between body and mind (Trondalen & Skårderud, 2007). In addition, they claimed that the "unity of senses" (p. 105) was as important as the client-therapist relationship.

Trondalen (2003) did a phenomenological research study to see the ways that self-listening promoted an experience of being connected within time and space. Trondalen (2003) defined self-listening as a variation of receptive music therapy where the client listened to their own performance to reflect on their experience, themselves, and remember musical, bodily and relational feeling memories. The theory was developmentally informed, and they related experiences through music and promoted growth in inter- and intrapersonal awareness and understanding (Trondalen, 2003). Trondalen (2003) did this work with a twenty-six year old named Julie diagnosed with AN, who had difficulty regulating her eating and emotions. Trondalen (2003) suggested that the listening experience supported Julie's procedural and emotional memories of feelings, which promoted a sense of belonging in time and space. The self-listening

experience enabled a way of connecting to the present through exploring the past as it provided motivation to grow (Trondalen, 2003).

Sloboda (1995) explained multiple case studies with individual music therapy on an in-patient unit. She provided treatment using Winnicott's concept of the "false self", or a defense that covers feelings of worthlessness and vulnerability because psychological and emotional pain are intolerable. Sloboda (1995) used free improvisation followed by image discussion. Sloboda (1995) was attempting to encourage the patients to symbolize their eating disorder through their instruments to provide a container for their emotional expression underlying their control. All the patients engaged in free improvisation, and Sloboda (1995) concluded that this allowed them to experience their emotions, develop confidence and strong self-expression, and engage in an interactive dialogue.

Robarts and Sloboda (1994) provided two case treatment studies of women with AN. Their theoretical orientation was a psychodynamic view with a focus on infancy and early attachment relationships with breaking down the defense of Winnicott's "false self." They provided treatment thorough musical improvisations with metaphor and symbolic play (Robarts & Sloboda, 1994). People with AN tend to suffer from feeling unworthy and have a deep lack of self-esteem, and have difficulty tolerating internal pain and conflict so they strive for external perfection (Robarts & Sloboda, 1994). Through musical improvisation, the patients were able to connect with their emotions and physical states, and reconstructed a sense of self through re-experiencing the organizational process of infancy (Robarts & Sloboda, 1994).

Robarts (1995) provided clinical music therapy improvisation to a thirteen year old girl with AN. Their theoretical orientation focused on a psychodynamically informed, Nordoff-Robins approach that incorporated the developmental self and object relations. The predominant complex needs and psychosomatic phenomena of adolescents suffering with AN concern ego-deficit, impaired self-identity and sense of autonomy, and issues of separation and individuation (Robarts, 1995). Robarts (1995) discussed a reconstructive therapy through music where a person's true self can begin to emerge in present time in terms of sensibilities, tensions and emotions. Robarts (1995) found that the phenomena of early self and self-in relationships could be expressed in musical dynamic forms, symbolic of the mother-infant relationship. This type of treatment can facilitate the process of ego maturation, self-identity, personal autonomy and the process of separation and individuation (Robarts, 1995).

Nolan (1989) utilized music therapy improvisation techniques in outpatient groups with three cases of women with BN. His theoretical framework was psychodynamically informed with a focus on Winnicott's transitional objects and transitional phenomena, and ego defense mechanisms (Nolan, 1989). He explained that music could be a replacement of food as the transitional object to bridge the inner state with the external world (Nolan, 1989). In addition, he stated music could replace maladaptive defense mechanisms and help a patient engage in regressive adaptation to develop healthy ego function. Nolan (1989) used therapist-structured improvisation and tape recording with verbal processing with the patients. The verbal processing allowed the patients to express their musical and emotional experiences verbally and concretely

(Nolan, 1989). Music therapy allowed for enhanced mobility of the ego as a release from external reality (Nolan, 1989).

Hilliard (2001) implemented a cognitive behavioral music therapy method with female patients diagnosed with EDs. He addressed traditional CBT goals of behavioral components, cognitive distortions, and faulty thinking through music therapy techniques (Hilliard, 2001). The music was provided for stress relief, decreased anxiety while eating and cognitive divergence for after meals (Hilliard, 2001). The patients identified and expressed anger through drumming, and gained insight into needing to change through lyric analysis of songs about change (Hilliard, 2001). The songs also allowed for an empowerment of women through singing feminist based songs, discussing woman pride, and identifying peer and personal strengths (Hilliard, 2001). The program was effective because it addressed ED issues through a non-threatening and supportive manner while challenging long-held cognitive distortions and destructive behavioral patterns (Hilliard, 2001). At the end of the program, the patients reported a sense of therapeutic success (Hilliard, 2001).

Yinger and Gooding (2014) reviewed the literature of music therapy and medicine available for children and adolescents. They found that the majority of the literature provided treatment for ED's through a humanistic approach. Yinger and Gooding (2014) use Darrow's (2008) definition of humanistic, which defines it as an interpersonal therapy. It is founded on the idea that improving a person's communication and relationship patterns increases their ability to function adaptively in daily life (Darrow, 2008). Music therapy also provided support, facilitated self-regulation and coping, and promoted self-awareness. In addition, music therapy in a group setting promoted

expression among individuals with AN, song themes that reflected a sense of identity and positive self-talk, and that cognitive behavioral music therapy enhanced patients positive affect about treatment. (Yinger & Gooding, 2014). The authors explained that these results showed promise in using music therapy as a treatment for individuals with eating disorders.

# CHAPTER 3: SYNTHESIS

## General Eating Disorders Literature Overview

The literature suggests that the underlying causes for eating disorders are multi-faceted as there is no one clear reason for its development. The central underlying causes reported in the literature are biologically, family-based, trauma-based, temperamental; and related to emotional regulation, and separation and individuation (see Table 1).

The literature includes biological factors as a possible determinant of eating disorders. This relates with sociocultural factors in terms of perceptions of body mass index, bodily changes and overall body dissatisfaction (Castro-Fornieles, 2015; Slevec & Tiggeman, 2011). Psychological factors tend to relate with biological factors, and can include elements such as depression and self-esteem. Temperamental factors include perfectionistic tendencies, harm avoidance and reward dependency (Agüera et al., 2012; Robarts & Sloboda, 1994). Family-based factors are another possible trigger and maintainer of eating disorders. Family-induced factors can include stressful family dynamics and partner relationships. However, these factors do not always create eating disorders as previously thought. Rather, the family can be affected when a client develops an eating disorder (Bulik et al., 2011).

The literature suggests that the sociocultural issues that contribute to the development of eating disorders are multi-faceted; however, the prominent issue is the idealization of thinness (Table 1). Thinness is discussed as an issue in the literature because it tends to provide meaning and reasoning for regulating an eating disorder (Castro-Fornieles, 2015; Kadish, 2012). It is a sociocultural issue because each culture can have its own set of rules impacting eating disorder pathology, and people often times use eating as a way to

control and rebel against their current or new cultural environments (Kadish, 2012). This is in conjunction with how people with eating disorders utilize a range of body management practices as a means for self-expression (Kadish, 2012; Fikkan, 2010).

Throughout the literature the underlying factor of trauma was mentioned as a possible cause for the development of eating disorders (Toto-Moriarty, 2015). Eating disorders are viewed as a coping mechanism for emotional dysregulation, so patients utilize it to cope with traumatic experiences to regain control of self, emotions and bridge the gap between internal and external states (Castro-Fornieles, 2015; Heal & O'Hara, 1993; Lejonclou & Trondalen, 2009; McFerran et al., 2006; Robarts, 1995; Robarts & Sloboda, 1994; Sloboda, 1995; Trondalen & Skårderud, 2007; Trondalen, 2003).

A significant portion of the literature described emotional dysregulation as a potential significant underlying cause for the development of an eating disorder. The treatment mostly aimed at increasing emotional regulation, as some of the literature suggests that ED's act as a mechanism for emotional dysregulation as food is easier to control (Heal & O'Hara, 1993; Hillard, 2003; Lejonclou & Trondalen, 2009; McFerran et al., 2006; Nolan, 1989; Robarts, 1995; Robarts & Sloboda, 1994; Sloboda, 1995; Trondalen & Skårderud, 2007; Trondalen, 2003). This was often connected with discussion about separation and individuation, prominent in the psychodynamic and CAT literature. More specifically, a mother who often times demonstrates higher neurotic temperamental tendencies leads to a decreased separation of mother and infant at the development of the crucial self (Robarts & Sloboda, 1994). This often causes decreased emotional regulation and necessity to display a "false self" and to use food as a transitional object to decrease anxiety and maintain equilibrium within the self and

external world (Heal & O'Hara, 1993; Hillard, 2003; Lejonclou & Trondalen, 2009; McFerran, Baker et al., 2006; Nolan, 1989; Robarts, 1995; Robarts & Sloboda, 1994; Sloboda, 1995; Trondalen & Skårderud, 2007; Trondalen, 2003).

**Treatment with Adolescents with ED**

A majority of the CATs and verbal treatment literature focused on adolescents with eating disorders. There were a few non-creative arts therapy sources available for middle-aged adults. The music therapy treatment literature often brought up two underlying causes: emotional regulation and separation and individuation. Music therapists, as well as art and dance therapists, used their modalities to help patients bridge unconscious and conscious processes, bypass defenses, regain connection between body and mind, decrease anxieties, and understand themselves through internalized emotional states (Fleming, 1989; Franks & Fraenkel, 1991; Heal & O'Hara, 1993; Hillard, 2001; Johnson & Parkinson, 1999; Krantz, 1999; Lejonclou & Trondalen, 2009; Luzzatto, 1994; McFerran et al., 2006; Morenoff & Sobol, 1989; Nolan, 1989; Padrão & Coimbra, 2011; Rice et al., 1989; Robarts, 1995; Robarts & Sloboda, 1994; Schaverien, 1995; Sloboda, 1995; Stark et al., 1989; Totenbier, 1995; Trondalen & Skårderud, 2007; Trondalen, 2003; Waller, 1995).

Music therapy literature described working through attachment, emotional regulation and interpersonal difficulties (Heal & O'Hara, 1993; Hillard, 2001; Justice, 1994; Lejonclou & Trondalen, 2009; McFerran et al., 2006; Nolan, 1989; Robarts & Sloboda, 1994; Sloboda, 1995; Trondalen & Skåderud, 2007). Robarts and Sloboda (1994) reported that patients developed a stronger sense of self as a result of music

therapy, and connected with their emotions and physical states through re-experiencing their organizational process of infancy. With this developmental focus in mind, the music therapists utilized music to help patients regain control, and bridge their inner and outer world to decrease anxiety due to difficulties with separation and individuation stemming from infancy and a lack of trust (Heal & O'Hara, 1993; Lejonclou & Trondalen, 2009; McFerran et al., 2006; Nolan, 1989; Robarts, 1995).

The psychodynamic psychotherapy literature also addressed past issues and explored them with adolescents (Dare, 1997; Dare et al., 2001; Lunn et al., 2015; Penny, 2005) similar to CATs therapists. The literature focused on how eating disorders can become a maladaptive coping mechanism for emotional dysregulation of past issues (Toto-Moriarty, 2015). In this context, psychodynamic authors using verbal treatment wrote more about the unconscious process for eating disordered behavior, and psychodynamic music therapy authors wrote more about helping patients gain an emotional understanding of the self and the self in relationship to others, and ego strength (Nolan, 1989; Robarts & Sloboda, 1994 Sloboda, 1995).

Psychodynamic verbal therapists also incorporated some behavioral interventions with a focus on decreasing binge eating and purging behavior for more quantifiable data, similar to that of CBT and family therapy (Dancyger et al., 2013; Murphey et al., 2005; Pouslen et al., 2014; Pouslen, Lunn, & Sandros 2010). Music therapy themes focused more on anecdotal responses in terms of themes of emotional regulation, Winnicott's "false self" (Nolan, 1989; Robarts & Slobodaa, 1994; Sloboda, 1995), song and lyric themes, improvisational techniques, separation and individuation, and developmental theory (Heal & O'Hara, 1993; Lejonclou & Trondalen, 2009; McFerran et al., 2006

Robarts, 1995; Trondalen & Skårderud, 2007; Trondalen, 2003). The majority of the CBT literature focused on changing disordered eating patterns to more adaptive eating patterns, changing cognitions, and measuring these factors through increased BMI, weight gain and decreased frequency of eating disordered behaviors (Anderson & Maloney, 2001; Latner & Wilson, 2000; Van den Eynde & Schmidt, 2008; Wilson & Fiarburn, 1998). Family therapist's also quantifiably measured therapeutic success through increase of BMI and decrease of eating disorder behavior frequencies (Dimitropoulos et al., 2015; Fairburn et al., 2012; Galsworthy-Francis & Allan, 2012; Lockwood et al., 2012; Murray, 2014; Ricca et al., 2009).

The overall approach to research for CBT was different as the objective was to help patients gain a new type of control for their eating disorder behaviors through making more adaptive patterns of eating the norm for their therapeutic goals (Anderson & Maloney, 2001; Latner & Wilson, 2000; Van den Eynde & Schmidt, 2008; Wilson & Fiarburn, 1998). A few CBT therapists focused on addressing challenges to change that were outside the diagnosis of ED, such as emotional dysregulation and family dynamics (Anderson & Maloney, 2001; Grave et al., 2014). Hilliard (2001) incorporated CBT treatment approaches with music therapy to change cognitive distortions, faulty thinking, and behavioral components to change destructive behavioral patterns. Hilliard (2001) states that the combination of CBT and music therapy approaches helped the patients challenge cognitive distortions, and gain insight.

Within the music therapy literature, the concept of separation and individuation was addressed within the patient themselves, rather than on outside relationships being affected by the eating disorder. Family therapy literature focused on decreasing the

pressure of the family or relationships, and provided psychoeducation about the eating disorder (Braden et al., 2014; Forsberg & Lock, 2015; Gelin et al., 2015; Marzola et al., 2015; Stewart et al., 2015). Family therapy focused on the strength of the family as a way of helping the adolescent gain normal patterns of eating and control over their own life.

The overall goal of most family therapy with adolescents with eating disorder in this context was re-establishing stable patterns of eating, and developing therapeutic goals for both the individual and the family. From there, the parents and family became more of a supportive framework (Forsberg & Lock, 2015; Murray & Grange, 2014; Stewart et al., 2015). Through helping the patients regain healthy weight and encouraging family support, family therapists provided adolescents a new meaning to their eating patterns and behaviors (Gelin et al., 2015; Marzola et al., 2015; Murray & Grange, 2014). Music therapists addressed this in their literature through focusing on developmental theory in working through exploring interpersonal relationships in both individual and group music therapy treatment (Dare, 1997; Dare et al., 2001; Lunn et al., 2015; Poulsen et al., 2010; Rolland, 2006; Tasca et al., 2012; Toto-Moriarty, 2015).

The music therapy literature included various theoretical orientations for treating adolescents with eating disorders. This writer inferred that a majority of the music therapy literature utilized psychodynamic approaches, while Yinger and Gooding (2014) found that a majority focused on humanistic approaches (Yinger & Gooding, 2014). However, their definition of humanistic as interpersonal therapy (Darrow, 2008) could be misleading, as other therapies involve an interpersonal approach. This writer found that music therapists were informed more by psychodynamic orientation. This often assisted with a more positive and realistic body and self-image, increased capacity to self-reflect,

transferring of mother and father relationships, and an increased awareness of their experiences within their inner and outer life that could trigger a binge (Dare, 1997; Dare et al., 2001; Lunn et al., 2015; Poulsen et al., 2010; Rolland, 2006; Tasca et al., 2012; Toto-Moriarty, 2015). There was minimal discussion of CBT techniques outside of Hillard (2001), and no discussion of family.

**Differences between Adolescents and Middle-Aged Adults with ED**

The underlying causes and sociocultural issues with eating disorders in general are more often researched for adolescents. However, there is a greater understanding of the effects on middle-aged adults (Gupta & Schork, 1993; Forman & Davis, 2005; Luca et al., 2015; Midlarsky & Nitzburg, 2008; Toto-Moriarty, 2015). Middle-aged adults with eating disorders tend to experience theses causes and sociocultural issues for a longer period of time, and at some points to a greater degree (Ackard et al., 2013; Doyle et al., 2015). Middle-aged adults reported body dissatisfaction similar to that of young women, and the literature suggests that it is because of sociocultural norms imposed on adults of thinness and youth (Gupta & Schork, 1993; Forman & Davis, 2005; Luca et al., 2015; Midlarsky & Nitzburg, 2008). Aging is often devalued by society, with a growing sense of preoccupation with body image (Mangweth-Matzek et al., 2014; Slevec & Tiggeman, 2011). Something that middle-aged adults share with their adolescent counterparts is the biological body transition. Puberty often increases the risk of eating disorders in adolescence, and menopause in midlife women (Mangweth-Matzek et al., 2014; Slevec & Tiggeman, 2011). Additionally, middle-aged adults women struggle with additional life

stressors of taking care of others due to the societal norm that women must take care of others first, such as children or dying parents (Mangweth-Matzek et al. 2014).

Again, the biological factor of BMI was most often documented by CBT treatment literature. The majority of researchers focused on increasing BMI with adults with ED (Carter et al., 2011; Darcy et al., 2015; Delvin et al., 2006; Fairburn et al., 2012; Mclean et al., 2011; Murphy et al. 2010; Pisetsky et al., 2015; Poulsen et al., 2014; Ricca et al., 2009; Waller et al., 2014). Dimitropoulos et al. (2015) also found that BMI increased in adults with ED as a result of the multi-family treatment.

The change in addressing the sociocultural issue of thinness is different within family therapy for middle-age adults. Since family therapy is geared towards adolescence and the parental control (Murray, 2014), treatment for adults focused more on couples. The eating disorder can become absorbed in the relationship causing perceived relationship pressure (Dare, 1997) and it is difficult because the relationship can be a source of therapeutic effect (Linville & Olekask, 2013). Rather than perceived effect of addressing sociocultural issues, many of the issues focused on gaining weight and perceived relationship status through attachment issues (Murray, 2014). The literature never addresses the issue of sociocultural factors of eating disorders, and rather focuses on changing eating disorder pathology through the system of couples and families (Dare, 1997; Dimitropoulos et al., 2015; Linville & Olekask, 2013; Murray, 2014).

The treatment outcomes for adults in CBT were similar with one modification of neurocognitive change (Darcy et al., 2015) and focusing on age-related appearance changes, self-care, body acceptance and self-worth in the context of midlife (Mclean et al., 2011). Similarities include decreasing eating disorder psychopathology (Fairburn et

al., 2012), and reduced disordered eating (Delvin et al., 2006; Fischer et al., 2014; Ricca et al., 2009; Pisetsky et al, 2015; Pouslen et al., 2014; Waller et al., 2014).

A significant amount of the psychodynamic treatment addressed the sociocultural issues of thinness through focusing on the relationship between eating disorders and defensive functioning for avoiding distress, and difficult thoughts and feelings (Hill et al., 2015; Lunn et al., 2015). In addition, the psychodynamic therapists focused on treating adult's interpersonal relationships, attachment patterns, how unconscious and conscious influences define ED symptoms, and self-esteem (Dare, 1997; Gallagher et al., 2014; Lunn et al., 2015). The psychodynamic approach did not directly treat the issues of thinness, but rather treated the eating disorder as a defense mechanism and explored ways it affected the interpersonal relationships of the clients. In addition, it addressed unconscious and conscious drives affecting the eating disorder symptomology (Gallagher et al., 2014; Lunn et al., 2015).

Luzzatto (1994) did provide art therapy to two middle-aged patients in the same study as an adolescent patient. She found that the images between all three patients were the same, and they symbolized their feelings with the eating disorder. Luzzatto (1994) found that the art demonstrated the patient's internal world, how it was projected onto the outside, and decreased fear when interacting with the external world. Luzzatto (1994) did not demonstrate a difference between the middle-aged and adolescent patients, nor explained differing techniques for both populations.

This writer had difficulty finding literature on dance/movement therapy treatment with middle-aged adults with eating disorders. However, the literature did not specify adolescents either. From the literature on general eating disorders with middle-

age, this writer assumes that many of the same interventions can be applicable to adults in middle-aged with modifications to focus on difficulties with menopause, aging and roles compared to younger patients.

A significant amount of the music therapy literature focused treatment on young adults, adolescents and children. In addition, most of the treatment literature identified there was more of an awareness of adolescents and children with eating disorders. Only recently has non-music therapy literature focused on treatment methods with middle-aged adults with ED. A few music therapists provided music therapy treatment to young adults (Heal & O'Hara, 1993; Nolan, 1989; Trondalen, 2003). However, only Hilliard (2001) includes adolescents to middle-aged adults in music therapy treatment in conjunction with CBT. The music therapy treatment literature with children and adolescents is included to provide information for recommendations for middle-aged adults with eating disorders.

**Music Therapy Treatment Recommendations for Middle-Aged adults with ED**

Based on the literature, music therapists should be aware of multiple theoretical approaches that can inform music therapy treatment of middle-aged adults with eating disorders. This writer suggests that a majority of music therapists were informed by psychodynamic treatment approaches (Lejonclou & Trondalen, 2009; McFerran et al., 2006; Nolan, 1989; Robarts, 1995; Robarts & Sloboda, 1994; Sloboda, 1995; Trondalen & Skårderud, 2007; Trondalen, 2003), with Hillard (2001) informed by CBT, and Justice (1994) utilizing a humanistic approach.

Helping middle-aged adults bridge the unconscious and conscious emotional states is another area music therapists should address when working with middle-aged adults with eating disorder, as well as working through Winicott's "false self." Music can assist in bypassing defenses and bringing unconscious emotional dysregulation into the conscious through relating experiences within the music (Heal & O'Hara, 1993; Nolan, 1989; Lejonclou & Trondalen, 2009; Sloboda, 1995; Trondalen & Skårderud, 2007; Trondalen, 2003). Some music therapy techniques that would accomplish this are song writing (McFerran et al., 2006), instrumental group improvisation (Nolan, 1989), and affect attunement through music improvisation by relating emotional experience through music (Lejonclou & Trondalen, 2009; Trondalen & Skårderud, 2007). For example, Nolan (1989) explained that the improvisation allows the therapist to connect with the patient on many levels, and it encourages the patient to experiment with behaviors with self and others.

This writer recommends that music therapists utilize music therapy improvisation interventions followed by song-writing interventions with middle-aged adults, with the goal of exploration of self and increasing emotional regulation. Some techniques the use of improvisation to access emotional material, verbally processing this experience, and then engaging in song writing about these emotions. Song writing following music improvisation encourages middle-aged adults to explore their emotions, identity, and express unconscious processes within a structured. These interventions could encourage a middle-aged adult to separate from the world around them and break through their "false self" (Fleming, 1989; Johnson & Parkinson, 1999; Luzzatto, 1994; Nolan, 1989; Schaverien, 1995; Waller, 1995).

Muisc therapists should consider a humanistic approach when working with middle-aged adults with eating disorders. Middle-aged patients often experience the same body shaming as adolescents, and sometimes to a higher degree (Forman & Davis, 2005; Gupta & Schork, 1993; Luca et al., 2015; Midlarsky & Nitzburg, 2008). In addition, a middle-aged adult often goes through similar bodily changes (Mangweth-Matzek et al., 2014; Slevec & Tiggeman, 2011), and this requires acceptance and understanding. If the humanistic techniques proved beneficial for adolescents, then they can be as effective for middle-aged adults. An example provided by Justice (1994) that can be used with middle-aged adults is music and movement in a group therapy session. This active physical play in a group provides a context for movement that is not based upon issues of calories and weight. The goal for this intervention would to become more comfortable with a wider array of movements, use and be aware of all parts of one's body, and be more comfortable using their body around other people (Justice, 1994). The attitude of enjoyment and play takes focus away from body perfection, and can include varying combinations of several simple experiences to rhythmic music (Justice, 1994). Music therapists should use movement experiences with caution, and within a structured musical environment.

Hilliard (2001) was the only music therapist in the found literature that utilized CBT techniques with music therapy. He found that it did help behavioral components, cognitive distortions and faulty thinking. The CBT literature did demonstrate quantifiable as compared to anecdotal efficacy of treatment with middle-aged adults with eating disorders (Anderson & Maloney, 2001; Latner & Wilson, 2000; Van den Eynde & Schmidt, 2008; Wilson & Fiarburn, 1998). Music therapists may want to consider CBT

approaches when treating middle-aged adults with eating disorders make eating an adaptive behavior when the patient is not seeking treatment for past traumas or emotional regulation (Anderson & Maloney, 2001; Latner & Wilson, 2000; Van den Eynde & Schmidt, 2008; Wilson & Fiarburn, 1998), especially for a short-term, in-patient setting and when the patient's medical status may be in danger.

Music therapists may wish to incorporate behavioral or CBT informed techniques while working through unconscious process. This can be done through providing psychoeducation (Lockwood et al., 2012), and understanding triggers for the eating disordered behaviors such as adverse experiences in social and biological factors (Poulsen et al., 2010; Toto-Moriarty, 2015). For example, in a music therapy improvisation the therapist and patient can address behaviors and cognitive distortions through group music making, while still facilitating emotional expression leading to the goal of increased emotional regulation. Another example is lyric analysis discussing the idea of weight with the inclusion of psychoeducation about adaptive eating patterns and understating social and biological factors. The music therapist can also work with other CBT professionals in the treatment team to provide a global treatment approach and explore shared and different goals.

Depending on the setting, music therapists should also include the dynamics of the patient's family in the session. This is more accessible in outpatient setting as opposed to in-patient settings, but music therapists can address relationships in the group context, and collaborating with the marriage and family therapists on the treatment team. An example music therapy intervention is a lyric analysis with middle-aged adults surrounding the theme of children, parents and possible partners. Certain themes and

dynamics might emerge that were not previously shared with the family therapist (McFerran et al., 2006). The music therapist can discuss with the family therapist the themes that emerged so the family therapist can incorporate these goals into their treatment. Within a group context, music therapists could address music relationships in a group improvisation intervention. If there is tension between two people, the music therapists can facilitate changes that translate outside of the music therapy session. Patients may also be able to address cognitive distortions that emerged through processing of the music therapy improvisation (Nolan, 1989).

Music therapy often helps adolescents regain an identity, and a sense of confidence. As middle-aged adults require increased confidence for the extra responsibilities they carry (Castro-Fornieles, 2015), music therapy can help develop their inner resources and support the journey from shame about who they are to confidence (Lejonclou & Trondalen, 2009). This writer recommends integrating lyric analysis with song writing interventions (McFerran et al., 2006). Music therapists encourage the patient to bring in songs they associate with their adolescence, and songs that resonate with them presently. After listening and analyzing the lyrics, the patient might bring up themes about not understanding who they were, and a projection of the mother onto the artist or subject of the song (Heal & O'Hara, 1993). This is especially true if the temperament of the caregiver had more neurotic tendencies, and did not allow for exploration of self (Robarts & Sloboda, 1994). The music therapist can then work with the patient over multiple sessions, composing the patient's identity song, and providing them with autonomy over instrument choice, chords, lyrics and overall themes.

McFerran et al. (2006) found that adolescents related to lyrics of identity formation, exploring new behaviors, relationship dynamics and relationship with the mother. It brought out material from the subconscious, as is a metaphorical way of accessing subconscious thought processes. These subconscious processes can then be transferred onto instruments in a group improvisation (Nolan, 1989). Another intervention recommendation is free-form music therapy improvisation. The music therapist will record the session for self-listening (Trondalen, 2003), and provide grounding and containment through specific rhythms and dynamics that encourage the patient to improvise (Sloboda, 1995). This might take time, as middle-aged adults with EDs are not comfortable without structure. After the improvisation, the music therapist should play back the recording and discuss their experiences, the emotions they associate with it, and body feeling memories during the improvisation (Trondalen, 2003; Nolan, 1989). Over time the sessions will become more structured to work through the different emotions heard in the first improvisation.

Given the lack of literature available on treatment with middle-aged adults and adolescents with eating disorders within a relationship context in music therapy, future music therapy research should focus on treatment within the relationship context. Family therapy found efficacy in both family therapy and couples therapy for patients with eating disorders, and some music therapists demonstrated themes of relationships appearing within treatment (Lejonclou & Trondalen, 2009; McFerran et al., 2006; Nolan, 1989; Robarts, 1995; Robarts & Sloboda, 1994; Sloboda, 1995). In addition, music therapy research for both adolescents and middle-aged adults with eating disorders should

incorporate quantifiable data such as BMI or weight gain to assess the efficacy of treatment and provide global treatment outcomes.

# CHAPTER 4: DISCUSSION AND REFLECTION

A common factor among the scope of the literature was that the treatment did not appear effective without the patient first building rapport and trust with the therapist (Toto-Moriarty, 2015). Often times this appeared to be the basic premise of therapy, and helped to provide a sense of safety for the patients. Although not discussed directly by authors, much of the interventions focused on the patient's history of the eating disorder and identifying coping skills (Fischer et al., 2014; Steward et al., 2015; Tasca et al., 2012; Yinger & Gooding, 2014), emotional regulation (Franks & Fraenkel, 1991; Fleming, 1989; Hill et al., 2015; Krantz, 1999; Johnson & Parkinson, 1999; Luzzatto, 1994; Nolan, 1989; Padrão & Coimbra, 2011; Robarts, 1995; Schaverien, 1995; Sloboda, 1995; Stark et al., 1989; Totenbier, 1995; Trondalen & Skårderud, 2007; Waller, 1995), and separation and individuation (Robarts, 1995). This suggests that rapport building and trust was necessary, as these topics mentioned require a high degree of vulnerability. Therapists also did not appear to change throughout treatment.

Music therapy treatment literature appeared to be most often informed by psychodynamic orientations, but there was a noticeable distinction between music therapy and psychodynamic verbal therapy literature. Psychodynamic therapists focused more on the unconscious processes that trigger eating disordered behavior (American Psychoanalytic Association, 2015; Dare et al., 2001; Lunn et al., 2015; Hill et al., 2015; Poulsen et al., 2010; Toto-Moriarty, 2015), while music therapists focused on exploring and maintaining emotional regulation, and bridging unconscious processes to the conscious realm through symbolic play and use of metaphor (Nolan, 1989; Robarts & Sloboda, 1994; Sloboda, 1995).

In psychodynamic verbal treatment, adolescent patients had the opportunity to explore unconscious processes that affected triggers (Toto-Moriarty, 2015), relationships (Bulik et al., 2011; Linville & Olekask, 2013) and body and self-image (Poulsen et al., 2010; Toto-Moriarty, 2015) through discussing past events. Middle-aged adults appeared to receive a more in-depth treatment into their past as they have had longer experience with their eating disorders. Psychodynamic treatment focused on exploration of their traumatic pasts and its effect on relationships and attachment, symptom reduction, and improved reflective functioning (Dare, 1997; Dare et al, 2001; Gallagher et al., 2011; Hill et al., 2015; Lunn et al., 2015).

In music therapy treatment, adolescent and young adult patients explored the themes of self-identity (Heal & O'Hara, 1993; McFerran et al., 2006; Robarts, 1995; Yinger & Gooding, 2014), relationships (Nolan, 1989; Robarts, 1995; Robarts & Sloboda, 1994) and emotions (Heal & O'Hara, 1993; Nolan, 1989; Sloboda, 1995; Trondalen, 2003) through bringing unconscious processes to the here-and-now. In addition, Hillard (2003) explained that the music itself provided some behavioral modifications to eating disorders through providing a new coping mechanism, and creating a distraction from possible cognitive distortions.

One thing that could enhance the music therapy literature is the inclusion of quantifiable data through a variety of assessment measures. The non-creative arts therapy literature assessed specific items to measure the long-term efficacy of treatment for both adolescent and adult patients. Efficacy was measured through BMI (Dimitropoulos et al., 2015; Fairburn et al., 2012; Galsworthy-Francis & Allan, 2012; Lockwood et al., 2012; Murray, 2014; Ricca et al., 2009), observed and self-reported frequency of eating

disorder symptoms (Gallagher et al., 2014; Hill et al., 2015; Galsworthy-Francis & Allan, 2012; Mclean et al., 2011; Pisetsky et al., 2015), and weight gain (Dare et al, 2001; Darcy et al., 2015; Fischer et al., 2014; Lockwood et al., 2012; Marzola et al., 2015;Murray, 2014; Padrão & Coimbra, 2011). The creative arts therapy literature relied on anecdotal data to demonstrate efficacy of treatment. Music therapists focused more on themes that emerged (Yinger & Gooding, 2014), such as emotions (Heal & O'Hara, 1993; Nolan, 1989; Sloboda, 1995; Trondalen & Skårderud, 2007; Trondalen, 2003), and identity (Heal & O'Hara, 1993; McFerran et al., 2006; Robarts, 1995; Yinger & Gooding, 2014). While important to the understanding of eating disorder pathology for both adolescents and middle-aged adults, it does not provide evidence for long-term efficacy of music therapy with this population. There might be some merit in combining the changes and emotions observed in the music therapy session with frequency of binge eating and purging behavior. This might help develop evidence-based interventions for both adolescent and middle-aged adults with eating disorders.

There was some focus in the music therapy literature of psychosocial interactions through group sessions. However, what seemed to be missing was the exploration of the impact of family dynamics on adolescents' eating disorders. The family therapy, and some psychodynamic literature, explored how family can be an effective tool for treatment through demonstrating positive attachments (Murray & Grange, 2014), providing positive support (Gelin et al., 2015; Marzola et al., 2015; Stewart et al., 2015) and continuing therapeutic strategies outside of therapy (Murray & Grange, 2014; Stewart et al., 2015). Music therapy could be a useful, non-verbal approach for exploring interpersonal relationships, especially with middle-aged adults, as music enables self-

expression in a group without verbal limitations. Although the psychological basis for healthy relationships often forms in adolescence, an adult's eating disorder treatment is positively affected by healthy relationships, and adversely has an impact on these relationships (Bulik et al., 2011; Dare, 1997; Dimitropoulos et al., 2015; Linville & Olekask, 2013; Murray, 2014).

When I began this capstone I was advised to consider doing research into my clinical internship population, which was psychiatric in-patient, oncology or children with multiple disabilities, because literature was scarce about my thesis topic. I also have personal experience with eating disorders, making this subject potentially harder to handle. However, through self-reflection I decided to challenge myself and learn about a new population. Writing a previous paper for class I was surprised to find limited literature on music therapy with adolescents with eating disorders, and nothing on middle-aged adults. I decided to combine my interest of middle-aged caregivers in hospice with learning more about music therapy treatment with eating disorders.

In the non-creative arts therapy literature, I observed that there was an increase focus on treatment with middle-aged adults with EDs. This appeared to come about because of the inclusion of binge eating disorder. From this, I concluded there was a gap in the music therapy literature on not only the eating disorder population, but also specifically middle-aged adults.

As I began my search, I discovered there was limited discussion about males with eating disorders, which is why my thesis is predominantly focused on women. A majority of the literature focused on middle-aged women with eating disorders. In addition, I had

to widen my search to include numerous definitions of middle-aged adults as many researchers defined it differently.

This literature helped me gain insight into understanding why women, and some men, might develop an eating disorder later in life. There were times when the research was difficult to read because it was written in an impersonal, overly professional style. Specifically, the non-creative arts therapy research focused more on weight gain and symptoms to support the effectiveness of the therapies. Something I felt that was missing was discussion about the humanity and life experiences of the individuals, especially the middle-aged adults. I understand that quantitative data is necessary to measure efficacy of treatment, and I believe that the inclusion of more anecdotal data will provide thorough treatment.

In the capstone process I had the opportunity to assess a middle-aged, self-identified female adult on the psychiatric unit for an eating disorder. The treatment team discussed that she appeared to be eating big meals, but not gaining weight. No previous history of eating disorders had been identified. In the music therapy group session, I assessed that she demonstrated eating disorder tendencies and behaviors. She refused to participate in the group unless her playing was “perfect.” From the literature, I learned that this is often presented in women with eating disorders as they feel their contribution could disrupt, or even be detrimental, to the group process and themselves (Nolan, 1989). In addition, whenever the client played the drum it matched the strong rhythms of the group, and remained at the same tempo and dynamic. When prompted to change, she stopped playing. Although this was not discussed in the music therapy literature, the art therapy literature did discuss that individuals with eating disorders are often controlled in

their movements. They refuse to do anything outside of a straight line. I translated this into music, and the control factor appeared to be the same. I attempted to use behavioral techniques to re-direct her and encourage her to participate as this was demonstrated to be effective in short-term situations, but the client appeared visibly uncomfortable. As this was a short-term unit, I was limited to the amount of treatment I was able to provide.

The most important concept I gained from this experience was that I accepted and validated that the patient had an eating disorder. Often times, middle-aged women feel embarrassed because eating disorders are considered an adolescent disorder (Ballard & Crane, 2014). I hope to use this example, and the literature, to dispel the myth that eating disorders are reserved for adolescents. In addition, I want to demonstrate how beneficial music therapy can be for both adolescents and middle-aged adults with eating disorders.

The hardest part of this literature review was starting from scratch for music therapy treatment recommendations for middle-aged adults with eating disorders. There was limited availability of music therapy literature on adolescents with eating disorders. Additionally, there was a lack of reliability of the treatments across the literature. Each music therapist(s) worked on different goals using different methods, making it difficult to find commonalities among the literature. One music therapy article incorporated CBT (Hillard, 2001) but with minimal discussion of deeper integration beyond using music therapy as a distraction for changing eating behaviors. It felt more geared towards behavioral therapy. I felt a lack of in-depth intervention description in the music therapy literature, but enough that I could recommend some basic interventions for middle-aged adults with eating disorders.

## Conclusion

There is a significant gap in the music therapy literature with middle-aged adults with eating disorders. There is presently an influx of new research on both adolescents and middle-aged adults in the non-creative arts therapy literature, and music therapy could have a significant impact on this population. With music therapy allowing for self-expression, demonstrating adaptive coping skills, identity exploration, bridging the unconscious to the conscious, and being a strategy for emotional regulation, there is untapped potential to expand the treatment options available for this population. Music therapy can help middle-aged adults effectively explore their relationship with their eating disorder, and their past. My hope is that the music therapy research within this population will continue to grow, and more middle-aged adults with eating disorders will be able to receive music therapy treatment to further enhance their journey to recovery.

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**APPENDIX A: TABLE 1**

**Underlying causes and sociocultural factors**

| Factors | Verbal Treatment | Music Therapy |
|---|---|---|
| Biology | Castro-Fornieles, 2015; Slevec & Tiggeman, 2011 | Hilliard, 2001 |
| Family | Castro-Fornieles, 2015; Gelin et al., 2015; Madowitz et al., 2014; Murray & Grange, 2014; Slevec & Tiggeman, 2011; Stewart et al., 2015 | Hilliard, 2001; Justice, 1994 |
| Trauma | Castro-Fornieles, 2015; Krantz, 1999; Lunn et al., 2015; Toto-Moriarity, 2012; Toto-Moriarty, 2015 | |
| Temperament | Castro-Fornieles, 2015; Slevec & Tiggeman, 2011 | Hilliard, 2001; Justice, 1994 |
| Emotion Dysregulation | Botha, 2015; Fleming, 1989; Franks & Fraenkel, 1991; Hill et al., 2015; Johnson & Parkinson, 1999; Krantz, 1999; Kirby et al., 2015; Lavender et al., 2015; Linville & Olekask, 2013; Luzzatto, 1994; Murphy et al., 2005; Padrão & Coimbra, 2011; Stark et al., 1989; Totenbier, 1995; Rice et al., 1989; Schaverien, 1995; Tasca et al., 2012; | Justice, 1994; Nolan, 1989; Robarts & Sloboda, 1994; Sloboda, 1995; Trondalen & Skårderud, 2007; Trondalen, 2003; |
| Separation and Individuation | Fleming, 1989; Johnson & Parkinson, 1999 Luzzatto, 1994; Waller, 1995 | Heal & O'Hara, 1993; Lejonclou & Trondalen, 2009; McFerran et al., 2006; Nolan, 1989; Robarts, 1995; Robarts & Sloboda, 1994; Sloboda, 1995; Trondalen & Skårderud, 2007; Trondalen, 2003 |
| Idealization of thinness and youth | Castro-Fornieles, 2015; Culbert et al., 2015; Fikkan, 2010; Kadish, 2012; Kinsaul et al., 2013; Levitt, 2004; Slevec & Tiggemann, 2011 | Justice, 1994 |