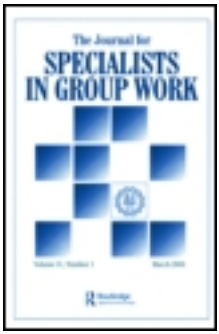

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Hitting Closer to Home: A Multiple Family Prevention Group for Adolescent Disordered Eating

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Hitting Closer to Home: A Multiple Family Prevention Group for Adolescent Disordered Eating

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This article presents an innovative multiple family psychoeducational group for the prevention of disordered eating among adolescent females. An overview of the concerns facing adolescents today is presented, including sociocultural norms, body dissatisfaction associated with pubertal changes, teasing regarding weight and shape, and family influences. Evidence regarding past prevention efforts are cited, indicating the need for the development of psychoeducational groups aimed at promoting familial systemic change for the prevention of adolescent disordered eating. Finally, a nine-session, psychoeducational multiple family group model for the prevention of disordered eating among female adolescents is described.

Keywords: *adolescents; disordered eating prevention; multiple family group work; psychoeducational groups*

Initially conceptualized by Laqueur and colleagues (Laqueur, 1972; Laqueur, Pa Burt & Morong, 1964), multiple family group counseling (MFGC) was established as a means for working with schizophrenic clients and their families in hospital settings (Asen, 2002; McFarlane, 2002). From its inception, MFGC blended traditional group and family counseling techniques, as well as attachment and psychodynamic theory and practice (Laqueur). From its outset, this form of group work involved four to five families and was effective for promoting positive communication and understanding among family members (Laqueur et al., 1964; McFarlane). Families learned through experience and modeling of other families' appropriate communicative expressions. Since that time, the MFGC approach has been implemented in a number of therapeutic settings such as hospitals, day treatment facilities, and mental health agencies (Asen; Bishop, Clilverd,

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Cooklin, & Hunt, 2002; Colahan & Robinson, 2002; Dare & Eisler, 2000; Lacqueur; McFarlane).

The power behind the MFGC technique appears to be in its allowance of family members to "learn by seeing parts of themselves in others, including their own dysfunctions" (Asen, 2002, p. 5). Like other group counseling formats, the MFGC approach provides a context for immediacy among members and encourages members to expect changes in themselves and other family members (Carlson, 1998). Such practices aid in the improvement of intra-family communication, promote larger systemic changes, and allow family members to identify with members of other families (Asen; Bishop et al., 2002). In addition, families are encouraged to socialize outside of the therapeutic milieu (Dare & Eisler, 2000; Scholz & Asen, 2001), which promotes continued understanding of the universality of their concerns. Further, the MFGC approach promotes change in the social contexts of families, thereby promoting adaptations in how family members think about and respond to the respective family member with the diagnosed concern (Bishop et al.).

As MFGC has been increasingly utilized, its usefulness as a counseling intervention with families with adolescents (with concerns ranging from schizophrenia to aggression to disordered eating) has been recognized (Asen, 2002; Carlson, 1998; Colahan & Robinson, 2002). In fact, MFGC is progressively used as a counseling intervention with both in- and outpatient adolescents with disordered eating concerns (Dare & Eisler, 2000; Scholz & Asen, 2001). Despite the success of these MFGC *intervention* programs with eating-disordered adolescents (Asen), based on a review of the literature, the authors found a paucity of research examining MFGC as a *psychoeducational prevention* tool with families who include adolescents at risk for disordered eating.

The purpose of this article is to describe an innovative, nine-session, multiple family psychoeducational prevention group (MFPPG) experience for families with adolescent females who are at risk for developing disordered eating habits. This MFPPG design takes the form of a structured, psychoeducational group intended for the prevention of adolescent females' disordered eating habits versus serving as an intervention after disordered eating has become a diagnosed, serious concern. Various group issues such as the need for and development of the group; group leadership; theoretical foundation; group membership, length, and inclusion criteria; screening; and group sessions are described. The design of an MFPPG for families with female adolescents at risk for disordered eating provides a timely example of how ethical and diversity-competent group leadership can be applied to an MFGC model, resulting in a unique hybrid of prevention and counseling techniques.

DISORDERED EATING: PREVALENCE AND RISK FACTORS AMONG ADOLESCENTS

While the lifetime prevalence of anorexia nervosa or bulimia nervosa is relatively uncommon in the general female population (0.5 percent and 1–3 percent, respectively), a subthreshold diagnosis of Eating Disorder Not Otherwise Specified (EDNOS) and disordered eating patterns are significantly more common (American Psychiatric Association [APA], 1994). The EDNOS diagnosis allows for eating disorders to be viewed as existing on a continuum from nonconcern with weight and eating at one end, weight dissatisfaction and moderately disordered eating in the middle, and the more severe pathologies of anorexia and bulimia nervosa at the other end. Anorexia and bulimia nervosa are relatively uncommon in prepubescent children; however, studies have found that approximately 40 percent of females in grades 5–8 report feeling fat and express the desire to lose weight (Massey-Stokes, 2001). Even more alarming is that adolescent females in the United States are 10 times more likely to suffer from a clinical eating disorder than their male counterparts (Schwartz, Phares, Tantleff-Dunn, & Thompson, 1999). However, male adolescents are also experiencing disordered eating as a result of the desire to conform to the muscular ideal for men as depicted in the media (Jones, 2004).

Distorted body image, negative body esteem, and periods of restricted dieting and/or binge eating are increasingly characteristic throughout puberty as female bodies undergo normative changes (Rohwer & Massey-Stokes, 2001). More specifically, the predisordered eating concerns facing female adolescents today include sociocultural influences, body dissatisfaction associated with pubertal changes and restrictive eating, teasing/harassment regarding weight and shape, and family modeling and influences (Davis, Shuster, Blackmore, & Fox, 2004; Jones; Phelps, Sapia, Nathanson, & Nelson, 2000). When left unaddressed, these personal and social concerns may develop into a severe disordered eating clinical pathology (Davis et al.; Phelps et al.).

Sociocultural Influences

Since the 1970s, as the cultural ideal for body type has grown increasingly thin, disordered eating has become prevalent among U.S. adolescents (Varnado-Sullivan & Zucker, 2004). As the rate of obesity in the U.S. increases, an alarming number of adolescent females are internalizing unattainable standards of beauty. The

growing sentiment of body dissatisfaction is believed to be a precursor to a strict regimen of dietary restriction in an attempt to achieve the "ideal" body weight and shape as dictated by society (Stice & Ragan, 2001).

In addition, Fredrickson and Roberts (1997) argued that the media's emphasis on female bodies led viewers to develop an implicit sexualized, objectifying gaze of these images. Females turn this objectification inward and take a negative observer's perspective of themselves and their bodies. This process was termed by Fredrickson and Roberts as "self-objectification" (p. 179). Adolescents who experience high levels of self-objectification become preoccupied with their own bodies and strive to achieve the culturally desirable body shape. In turn, females may over-adapt and develop extreme dieting methods and behaviors in an attempt to achieve desired outcomes.

Body Dissatisfaction and Restrictive Eating

Adolescence is often viewed as a transitional period characterized by numerous normative pubertal and physical changes (Rohwer & Massey-Stokes, 2001). While the onset of puberty can occur as early as age seven and as late as age 18, 50 percent of all boys and girls reach puberty by the age of 13 (Rohwer & Massey-Stokes). Adolescents are often startled by the characteristic physical changes their bodies experience as they become heavier and differently shaped. When experiencing an early onset of pubertal changes, this transformation may be associated with heightened body dissatisfaction and lower body esteem. Body esteem is reported to decrease throughout elementary school as girls approach puberty (Smolak & Levine, 2001), and body dissatisfaction may lead to adolescent disordered eating. In fact, body dissatisfaction is the single strongest predictor of disordered eating symptomotology (Phelps et al., 2000).

Most alarming may be the dieting behaviors that have become increasingly common in young females; some as young as nine report restricted caloric intake in order to lose weight (Massey-Stokes, 2001). Restrictive dieting is a risk factor for the development of disordered eating because a period of restricted eating often marks the onset of binge-eating behaviors (Fisher & Birch, 2001; Rohwer & Massey-Stokes). In addition, severe caloric deprivation may be a direct result of familial or peer pressure and/or teasing (Fisher & Birch).

Teasing and Harassment

High levels of perceived teasing and/or harassment about physical appearance are also associated with negative effects in both obese and

nonobese individuals and with the onset of disordered eating (Jones 2004). Teasing appears to have prolonged and sustained effects; women who were teased during their childhood report higher levels of body dissatisfaction in adulthood (Jones). Despite the prevalence of teasing from peer groups, Rieves and Cash (1996) found that brothers and other male family members were the most frequently reported perpetrators of teasing behaviors and were reported to be the "worst offenders."

Family Influences

Perhaps the most influential ecological factor in the development of body disturbance is that of the family (Abramovitz & Birch, 2000; Colahan & Robinson, 2002; Smolak & Levine, 2001). Children's inclinations for certain foods are believed to develop during the fetal and nursing periods and are dependent on mothers' diets (Fisher & Birch, 2001). As children grow, parents model appropriate or inappropriate eating behaviors and body esteem attitudes for their children. Similarities between parent-child food intake and behaviors are established early and are especially evident between mothers and children (Fisher & Birch; Massey-Stokes, 2001). Parents' dieting behaviors and negative comments regarding their own bodies are positively correlated with their children's elevated feelings of body dissatisfaction (Smolak & Levine). For example, in girls as young as five, the development of awareness and ideas regarding dieting were predicted by their mother's dieting behaviors (Abramovitz & Birch). Parental modeling is also evident in the statements made to children about their body shapes because many parents actively encourage weight loss or gain in their children; as such, parental comments affect children's body image and esteem (Smolak & Levine). In a retrospective study of college women, the strongest predictor of bulimic symptomotology was negative comments from family members about physical appearance and needing to lose weight (Davis et al., 2004).

Finally, family functioning also is linked to body image and eating disturbances among adolescent females (Colahan & Robinson, 2002). Family interaction style appears to have differential effects on the development of eating disturbances; families marked by significant rigidity and dependency may foster restrictive dieting in their children, whereas familial chaos as characterized by isolation, hostility, and decreased nurturance is related to binge eating behaviors (APA, 1994). Fortunately, the MFGC format is currently utilized as an efficacious counseling intervention for families and female adolescents with disordered eating (Asen, 2002; Colahan & Robinson). Indeed, it

has been observed that MFGC efforts produce faster behavioral change than the treatment of individual families (Carlson, 1998). Despite its noted success as a counseling intervention, there is a paucity of research in the utilization of MFGC as a psychoeducational prevention approach.

ADOLESCENT DISORDERED EATING: PAST PREVENTION EFFORTS

Despite the profound influence of families on adolescents' eating habits and body esteem, counseling practice rarely includes families in the prevention efforts regarding disordered eating. Prevention programs tend to be targeted at the school level and are based on one of two theoretical models: the disease-specific pathways model (DSPM) or the nonspecific vulnerability-stressor model (NSVSM) (DalleGrave, 2003). The DSPM focuses on the elimination of risk factors to reduce the likelihood that an eating disorder will develop, whereas the NSVSM assumes that there is a nonspecific relationship between life stress and lack of social support and coping skills. NSVSMs enhance self-esteem and develop general life skills to increase coping (DalleGrave).

A review of prevention literature revealed limited successful prevention programs; however, the most successful are those that utilize an interactional format and do not specifically address the diagnostic criteria of eating disorders (Levine & Smolak, 2001; Varnado-Sullivan & Zucker, 2004). Recent programs have included a critique of sociocultural norms, teaching young females how to advocate against conforming to the unhealthy ideals depicted in the media (LeCroy, 2004; Phelps et al., 2000). Piran (1999) assessed the efficacy of a school-based, multiyear, eating disorder prevention program which included multiple changes at the larger school level as well as small focus groups throughout each year. The focus groups were utilized to curtail teasing, mutual evaluations of shape, criticism of the sociocultural emphasis on thinness, and peer-to-peer harassment. Over 10 years of follow-up, participants indicated decreased disordered eating, increased positive body esteem, and advocacy for the natural diversity of body types. The program's success may be due to the larger systemic intervention, allowing students to receive consistent messages regarding healthy living.

In an attempt to promote systemic change at the school and family level, Varnado-Sullivan and Zucker (2004) developed the Body Logic Program (BLP). This program is a primary prevention program

focused on the improvement of body image, nutrition education, and the fostering of coping skills to combat teasing and accept normative pubertal changes. The program is discussion-oriented and adopts cognitive-behavioral strategies to combat against irrational beliefs regarding the malleability of bodies and the necessity to conform to sociocultural norms. In addition, Varnado-Sullivan and Zucker noted the importance of providing an educational component for teachers as well as family-based interventions. While initially implemented with both male and female students in grades 6–7 over three sessions, results indicated that the BLP decreased fear of fatness and fear of food in female participants.

The BLP was initially designed as a universal primary prevention program (Varnado-Sullivan & Zucker, 2004). However, targeted programming has led to the most encouraging outcome data (DalleGrave, 2003). As a result, Varnado-Sullivan and Zucker included an intensive family-based intervention for participants who were designated as at-risk for the development of disordered eating. This program, Body Logic Part II, is conducted in a small group format and includes exercises to supplement the coping skills developed during the school-based intervention. Despite its strong theoretical underpinnings and the need to include the family in prevention efforts, this program has yet to be empirically evaluated.

Given the limited group *prevention* efforts that currently exist for female and male adolescents at risk for disordered eating, the need for the development of prevention efforts aimed at promoting familial systemic change, and the proven efficaciousness of MFGC interventions, the authors designed this psychoeducational MFPPG model for the prevention of disordered eating in female adolescents. It is important to note that the model can easily be adapted for use with male adolescents and their families as well. The authors suggest offering gender-specific MFPPG experiences for either female or male adolescents and their families due to the significant differences in body dissatisfaction and loss of body esteem that females and males experience (Jones, 2004; Presnell, Bearman & Stice, 2004).

The main goals of the proposed group are to provide participating families with a safe, therapeutic environment to: (a) promote the enhancement of self-esteem and body esteem among adolescent girls and their families; (b) offer a forum for participants to challenge sociocultural norms of attractiveness; (c) educate participants regarding healthy living, focusing primarily on eating and exercise practices; (d) teach and develop coping skills to deal with teasing and sexual harassment; and (e) enhance familial cohesion and communication. The group format models the NSVSM as discussed by DalleGrave (2003).

MULTIPLE FAMILY PSYCHOEDUCATIONAL PREVENTION GROUP MODEL

Leadership and Theoretical Foundation

The MFPPC experience poses a unique set of circumstances, and, as such, it is necessary that group leaders receive the appropriate supervision and training in this area and feel comfortable with facilitating this distinctive process. The number of group leaders for this model should vary according to the size of the group; however, it is imperative to note that the group requires a multidisciplinary team that should consist of professionals from a variety of backgrounds (Scholz & Asen, 2001). We suggest that the primary group leaders be master's-level and/or doctoral-level professional counselors and psychologists who have been trained in group counseling techniques; the leaders should represent professional backgrounds such as counseling or psychology. While this group may be facilitated by master's-level practitioners, it is advised that they be licensed professional counselors and that all leaders have been supervised in working with adolescents at risk of developing disordered eating. The number of leaders active in the group should vary based on group size; however, it is recommended that there be approximately one leader per family (Scholz & Asen). In addition, the primary leaders should plan to involve other professionals throughout the group experience that represent backgrounds such as psychiatry, nutrition, and/or exercise. Having group leaders from a plethora of professional backgrounds allows for a heightened degree of awareness in their areas of specialization and provides the opportunity for the various leaders to engage in different tasks at any given time (Scholz & Asen).

Theoretical orientation may vary among leaders, but it is essential that at least one leader be proficient in the area of cognitive-behavioral therapy (CBT) because it is often considered the gold standard in the treatment of disordered eating (Wilson & Pike, 2001). Additionally, group leaders should be comfortable working with components from the family systems theoretical background (Bowen, 1976) and easily facilitate here-and-now dynamics of the group (Yalom, 2005). Due to the inherent subgroups that emerge within this context (i.e., family, family-role, and gender subgroups), leaders must also be comfortable mediating and facilitating intentional subgroup activities and discussion throughout the course of the group. These subgroup experiences can consist of activities with all females in one group and all males in another or all mothers and fathers in one group, all female adolescents in a group, and all male adolescents in a group, etc. Also, intentional subgroup work provides additional opportunities for all

family members to participate in the MFPPG process and increased leader opportunities to address member concerns thoroughly. In addition, all group leaders should be familiar with the NSVSM method of prevention as described by DalleGrave (2003). The NSVSM takes an interactional format and focuses on fostering positive coping skills, rather than didactically educating members about disordered eating. Coping skills should be consistently reinforced throughout sessions and tailored to the specific needs of the group (Corey & Corey, 2002; Yalom). As such, leaders must be comfortable adapting their styles as needed within each session and with each family.

Recruitment

Adolescents who may benefit from such a prevention effort can most easily be recruited for the group through their schools and athletic programs. In addition, co-leaders can notify local community groups such as Weight Watchers and religious/spiritual organizations about the family group opportunity. It is through such organizations as these that parents could be reached and could ask questions and receive more information about the possibilities of such a psychoeducational group experience. During recruitment efforts, parents and members of families should be openly informed of the possible effects family systems can have on one specific family member's behaviors or patterns and how this group experience addresses prevention as a family effort as well. This information can be included in literature and verbal announcements pertaining to the group. All school and community counselors and organization leaders should be contacted by group leaders and informed of the purpose and goals of this group. With permission, group leaders should visit these organizations for advertising and recruitment purposes. Parents, teachers, coaches, and school counselors will then have the information they need to brainstorm which adolescents/students might benefit from this psychoeducational group. Once these adults have the group leaders' contact information, they should be encouraged to consider who they might refer (adolescents and families) and have them make contact with the group leaders or offer the leaders the families' contact information.

Once eligible adolescents/students and their families are referred, group leaders should contact each family regarding the program. Initial contacts should be made by telephone; however, parents should be asked to assess their family's degree of interest and commitment before agreeing to participate. All families indicating the possible desire to participate should be contacted via telephone by one of the group leaders to determine an in-person screening time.

Screening

Two screening interviews per family are encouraged: one with the adolescent identified as at risk of developing disordered eating and one with the adolescent's participating family (Scholz & Asen, 2001). It is not necessary for siblings to be present at the prescreening interview; however, the adults who contribute to raising the adolescent should be present as possible. The two separate interviews serve multiple purposes. First, by screening the adolescent alone, leaders will be able to accurately assess the adolescent's level of body dissatisfaction and restrictive eating, as well as determine the existence of other pre-existing pathologies, if any. The group should be presented to the female adolescents as a prevention group that focuses on healthy body image and positive eating and exercise habits. Adolescents who exhibit severe eating, dieting, exercising behaviors or other psychopathology or who do not show a basic level of commitment to learning more about health and appropriate eating patterns should be excluded from the group. It is likely that including adolescents already exhibiting such harmful behaviors may have detrimental effects on group goals and compatibility (Corey & Corey, 2002). Per the leaders' expertise, participating adolescent females should be compatible with one another and have an awareness of their concerns around body satisfaction and eating patterns. In addition, the female adolescents involved should be within a two-year age range (Dare & Eisler, 2000; Scholz & Asen).

The extended-family screening interview is designed to assess familial attitudes and behaviors surrounding food and body shape/size, as well as communication styles. Those families with adolescents who exhibit the greatest potential for eating-related pathology should be given priority for admittance into the multiple family psychoeducational prevention group (MFPPG). As is the case with the adolescents, parental psychopathology should be evaluated, and information should be gathered regarding psychological disturbance among other family members who may participate in the group. This information might include parents' or others family members' histories with food, dieting, and/or disordered eating. All families should be informed of the basics of the MFPPG experience, and they should be allowed to ask questions. The entire family's willingness to participate should be determined. Family screenings should assess current behaviors and concerns within the family system that may be affecting the adolescent's body esteem and eating patterns. For instance, are male family members exhibiting behaviors or using verbal taunts that might affect the adolescent female's body esteem and development? Or is her mother modeling specific eating or dieting habits? If so, leaders

should explore these behaviors with the family members and inform them on how these topics will be addressed within the group. In other words, all members of the family should be prepared to focus on their own behaviors as they learn more about how the family system can help or hinder the adolescent female's body esteem and eating patterns. It is important to note that partial family membership will be recommended for girls whose fathers or male siblings are not able to interact appropriately with them.

In addition, leaders should exclude families with severe eating or drug use pathologies, noncommitted family members, and family members with concerns about the actual within-family and between-family process of this psychoeducational prevention group. If a family or the leaders believe that the group is not appropriate for them at that time, referrals should be made. In addition, group leaders should be sensitive to the varying interactional styles and structures of families, including single parent, step-parent, and gay and lesbian family structures (Corey & Corey, 2002). Concerns about diverse family structures and families with additional significant concerns other than the adolescent's behaviors (e.g., alcoholism or drug use, physical abuse, etc.) should be considered by leaders during the screening and selection processes. Finally, potential members should be informed about possible safety issues around the 30-minute, basic yoga session that will occur during session five so that they may choose whether they will participate in that particular activity. Those members who cannot or choose not to participate in the yoga should still attend the full 90-minute session; however, they can observe the other group members. If they believe basic yoga is not appropriate for them or their physical capabilities, leaders can suggest an alternative activity such as walking or deep-breathing exercises.

Group Membership, Length, and Inclusion Criteria

Due to the extreme pressures placed on young women in today's society to achieve the body ideal and their heightened risk in the development of disordered eating, it is recommended that these groups be gender-specific in relation to the identified females at risk for disordered eating (Phelps et al., 2000). Additionally, a review of the literature reveals that young girls may be more adversely affected by negative comments within the family regarding weight and shape than their male siblings (Schwartz et al., 1999; Smolak & Levine, 2001). Utilization of the MFGC format of eating disorder intervention has previously brought together four to eight families at a time (Asen, 2002; Dare & Eisler, 2000). Therefore, for this prevention effort, it is recommended that this group be comprised of four to six families in

order to meet the needs of all members (Carlson, 1998). The number of co-leaders should mirror the number of families participating. The actual size of each participating family should also be taken into consideration when determining how many families to which to extend membership because a group exceeding 20 members may become cumbersome and impede group learning and process. It is imperative that leaders be able to actively facilitate group and family discussions, as well as strive to give equal time to each of the families as necessary. Regardless of gender, all immediate family members are encouraged to attend in order to affect the entire family system more fully (Bowen, 1976). As necessary, extended family members who are active in the adolescent's life should be invited to participate. Sessions should run approximately 90 minutes in duration and meet once a week over the course of nine weeks.

Familial compatibility with this group experience should be assessed from multiple perspectives. Research has shown that prevention groups are most successful when targeted to the at-risk population (DalleGrave, 2003). As such, those adolescents at the early stages of pubertal development who indicate elevated levels of body dissatisfaction, restrictive eating, and/or those with higher body mass indices can be recruited for participation through their schools. Willingness and availability of the entire family is essential. An inability for all family members living in the adolescent's home to participate in the group may be considered an exclusionary criteria, since full involvement is necessary to most greatly impact the family system. However, for adolescents experiencing heightened levels of body and eating disturbance, and therefore considered most at risk for developing disordered eating, leaders may choose to allow partial-family membership.

Due to the nature of this MFPPG approach, heterogeneity among the large group will be determined by the composition of the larger society in which the groups are conducted; a fairly heterogeneous area will more likely lead to the establishment of a group in which families come from a variety of different socioeconomic, racial, and ethnic backgrounds. A more homogeneous community will not represent this kind of variability. Group leaders should be aware of the dynamics and diversity of the community from which their group will be drawn, be prepared for the apparent diversity in a group this large, and be experienced in addressing needs of members in gender-diverse and other multiculturally competent manners (Association for Specialists in Group Work [ASGW], 1999; Corey & Corey, 2002).

Although the proposed group is targeted at adolescent girls, it should be noted that slight alterations to the curriculum may allow for the utilization of this programming with adolescent males. Jones

(2004) noted that in recent years the degree of body dissatisfaction reported by adolescent males has flourished. However, unlike their female peers, males generally report a desire to conform to the muscular ideal for men as depicted in the media. As such, males who are both over *and* underweight for their age and height may be considered at risk for developing disordered eating and elevated levels of body dissatisfaction (Jones; Presnell et al., 2004).

Selection and Preparation

Upon completion of the screening interviews, group leaders should meet to determine who will be invited to participate in the MFPPG experience. Admittance to this prevention group should be determined by the female adolescents' concerns regarding weight, shape, and eating, as well as evidence of negative familial attitudes toward food and body dissatisfaction. These behaviors and attitudes are assessed within the screening process using direct questions concerning family members' ideas and behaviors around dieting, exercising, eating habits, and body ideals. Communication styles and family structures should also be taken into account when looking at the overall compatibility between participating families.

Once the ideal group has been determined by the leaders, families are notified and asked to convene for a pregroup meeting. This meeting is designed to allow group members to meet and be briefed on the MFPPG process as well as to obtain informed consent from all participants. Members should be given a calendar listing all meeting dates and topics to be covered on each of the evenings. Questions concerning the logistics of the group and leader expectations regarding attendance, promptness, and participation should be addressed within the screening process as well as in the first session of the group.

Potential Group Stages and Dynamics

While psychoeducational in nature, the makeup of the MFPPG approach is such that members are afforded opportunities for process throughout the course of the group. The NSVSM, from which the MFPPG is developed, emphasizes the importance of interaction among members. Throughout its duration, MFPPG may take on a unique hybrid of psychoeducational and counseling processes. As a result, it is possible that group dynamics, stages, and roles may develop as put forth by Yalom (2005) and Corey and Corey (2002). Group leaders must be aware of these stages and their potential impact on group processes. Depending on the group composition, these stages may or may not evolve over the course of the nine week prevention program.

Corey and Corey (2002) noted that, like adults, adolescents are often hesitant to engage in self-disclosure during the initial stages of the group. If the leaders are successful in engaging group members and encouraging safe disclosure, the initial stage—as marked by focus on others, resistance, hidden agendas, and mistrust—will give way to the transition stage of the group (Corey & Corey). In this stage, conflict within and between families may emerge. Group leaders' facilitation of the development of group norms and deepening of trust increases the likelihood that the group will progress into the working stage (Corey & Corey). Yalom (2005) views this stage as being marked by commitment to change, willingness to take risks, cohesion, confrontation, and self-disclosure. While each group will progress through these stages at varying rates, it is anticipated that by the end of the nine weeks, the MFPPG as proposed below will have reached the working stage and will allow for positive growth and the development of communication skills in and between families.

GROUP SESSIONS

Session 1: Introduction and Goal Setting

The first session of the group should be primarily dedicated to introducing group members to each other and the group process (Corey & Corey, 2002). Icebreaker activities should appeal to a variety of ages and be focused on allowing interaction between families. In this initial session, leaders should focus efforts on breaking up family cliques in order to promote between-family group cohesion. It is recommended that families specifically be given the opportunity to meet and interact with members of other families who share their family roles (i.e., mothers, interact with mothers, children with children, etc.), thereby promoting intentional subgroup interactions from the onset.

The first session should also be focused on establishing group norms and rules (Corey & Corey, 2002; Yalom, 2005). Creating these rules should be dictated primarily through group discussion but mediated by group leaders. Group leaders should be willing to offer suggestions and help group members to explicitly state their desired rules in order to make them more concrete. As with any group, the importance of confidentiality must be stressed (Corey & Corey). Additionally, it is crucial that leaders discuss the limitations of confidentiality within the group setting while encouraging members not to disclose private information revealed in session with people outside of the group.

Group leaders should again remind members of the overall goals of the group and work with members to create a supplemental list of goals,

specific to each family. The development of group, family, and individual goals may take place in a variety of ways. It is recommended that, in a group with four participating families, the leaders break the families into two groups to allow for the opportunity to begin direct contact between families. In these small groups, the families may work together with two leaders to develop appropriate full-group goals. Following the creation of these goals, the two groups will then be brought back together, and both groups will be encouraged to share their lists. Following group discussion, a final list of goals will be created and displayed in a prominent place—along with the group rules—throughout the entirety of the nine weeks. Family goals should then be addressed by having a leader assigned to each family to facilitate the development of family goals. These goals should be unique to the circumstances and needs of each family. Finally, each member will be given the opportunity to develop a set of goals as appropriate for them as an individual. It is recommended that at least one leader check in with each member—particularly the adolescent girls—in order to ensure that individual goals are in line with the overall purpose of the multiple family group (MFG). For example, a participating adolescent may desire to improve her relationship with her mother, identify potential triggers of binge-eating episodes, and/or learn positive coping skills to deal with peer teasing in the schools. In the end, the group should have group goals, family goals, and individual member goals.

Sessions 2 and 3: Understanding Body Image in a Sociocultural Context

Understanding body image and promoting positive body esteem is a pivotal aspect of this group. As a result, the second and third sessions should be devoted to (a) defining body image; (b) promoting individual members' understanding of their own body images and how these play a role in their everyday lives; (c) recognizing how an individual's body esteem may be linked to sociocultural ideals; (d) understanding and appreciating the natural diversity of bodies; and (e) enhancing the individual's ability to challenge sociocultural norms of attractiveness.

The first priority in these sessions is for group leaders to work with members to define the concepts of body esteem and body image. This should be completed in two ways, first with subgroups of all females and all males and then as a large group. Females and males are likely to differ in their definitions and experiences with these constructs; thus, the early gender-specific subgroups may aid them in being more open and honest with themselves and others about their understanding of body esteem and diversity of bodies. Within the subgroups and in the large group, leaders should encourage and facilitate discussion

of how body image is unique to each individual and how each person's body image affects their own lives. It is important to realize that body esteem may be more salient for some members of the group than others. These differences may be the result of pubertal timing and subsequent changes as a result of puberty, as well as life experiences, body shape, and body esteem schema. (Rohwer & Massey-Stokes, 2001). Group leaders should be prepared for these differences and be able to attend to each member's concerns as necessary. For example, Shannon, a 12-year-old girl who underwent puberty at age nine, is dissatisfied with her body, which she views as being significantly heavier than her peers. Carrie, age 13, has yet to go through puberty.

Shannon: I hate my body. My breasts are so big that I can't run the way I used [to]. And they make me look so much fatter than everyone else.

Carrie: Well at least you *have* breasts. I think guys prefer big breasts.

Leader: What we all need to understand and be aware of is that *many* people find something wrong with their bodies or want to change something about themselves. While you both have very different body types, you both want to change the same body part—let's talk about some of the reasons for that.

At this point, the leaders facilitate a conversation among the group focusing on the adolescent group members and their desire to change their bodies. Through exploration of these concerns, the group as a whole realizes that the girls' dissatisfaction with their breasts is rooted in their feelings of isolation because they look different from their peers. The leaders may then elect to model and engage in cognitive restructuring to combat irrational beliefs regarding the need to look like everyone else in order to fit in. As they model these CBT techniques, they can then ask parents and other family members to try them out within their own families.

Body esteem is often dictated by an individual's conceptualization of her or his body in a sociocultural context, since many people develop and experience body dissatisfaction as the result of comparison to cultural ideals (Stice & Ragan, 2001). Group leaders should address how society dictates what is considered attractive, as well as offer information regarding the evolution of sociocultural norms of attractiveness. In addition to the female standard of thinness, leaders must additionally be cognizant of standards of attractiveness that may be salient to males in the group. Western sociocultural mores dictate a muscular physique for males (Jones, 2004), and related concerns from male members must be addressed. In order to address the issue of body esteem and body image for both male and female group members most fully, leaders

can facilitate intentional subgroup discussions regarding sociocultural standards of attractiveness. In such a situation, leaders would divide the larger MFPPG in two smaller subgroups based on gender. This division may allow members to feel more comfortable expressing their own views regarding cultural standards and their own bodies without the presence of the opposite gender. For example, in the female subgroup, the group leaders provide an image of Marilyn Monroe and present it for discussion. Caroline, Carrie's mother, reacts quickly:

Caroline: Oh, Marilyn Monroe—she was so beautiful.
Shannon: Yeah, she's really hot—I'd love to look like her.
Leader: All right Shannon, tell me, what makes Marilyn Monroe so beautiful?
Shannon: Well, I don't know, like everything. She's perfect. Look how sexy she is!
Caroline: You know I heard somewhere that Marilyn Monroe was a size 12.
Shannon: No way, she's got to be like a four.
Leader: No, Caroline's right. Marilyn Monroe was a size 12. In the 1950s and 1960s—and even today—Marilyn Monroe was considered gorgeous. It wasn't until Twiggy, a model in the 1960s, that actresses and models started to look like what we think of now.
Carrie: Yeah, now you couldn't model if you were over a size zero.
Shannon: I don't think that's true. What about plus-size models?
Leader: That's true. Today, there are a lot of things that make people beautiful—even beyond their physical appearances. Tell me, what makes someone beautiful to you?

The conversation may then move to what makes a person beautiful. Leaders should continuously encourage all members to participate in the discussion. Special attention should be given to aspects of beauty that go beyond the physical realm.

Finally, visual images of the diversity of beauty within diverse yet current contemporary countries and societies should also be provided. Group leaders should facilitate discussion regarding how to recognize and challenge sociocultural norms and empower members to explore ways to affect necessary changes in the media's portrayal of beauty. Images of variation in cross-cultural standards of beauty should include both male and female pictures. Throughout these sessions, leaders may choose to engage in cognitive restructuring with the group members in order to most successfully combat against sociocultural standards of beauty.

Sessions 4 and 5: Tools for a Healthy Life

Dieting has become a way of life for many Americans. However, as fad diets come and go with great flourish, few understand what it

means to eat healthy. Dieting, as many Americans view it, entails restrictive eating; however, it is important to stress that restrictive eating is highly correlated with periods of binge eating and subsequent disordered eating habits (Massey-Stokes, 2001). The goal of sessions four and five is to educate group members regarding healthy eating, as put forth by U. S. Department of Agriculture Food Pyramid Guidelines. Group leaders should be familiar with current guidelines, which call for the utilization of one of 12 pyramids based on age, gender, and exercise habits (USDA, 2005). Families should be encouraged to complete a general outline of food consumption over the course of the week and, as a group, critically examine intake and analyze how the family can develop healthier patterns in the future.

As noted above, restrictive eating is highly correlated with binge eating and other disordered eating habits. Since these sessions are devoted to the encouragement of healthy eating behaviors, leaders should facilitate the identification of triggers to binge eating habits as experienced by each member. CBT-based positive coping skills should also be discussed and, if needed, taught to the adolescent females. For example, Susan, an adolescent group member, and Phil, her father, have both identified being bored as a trigger for compulsive eating. Maryanne, the mother of another adolescent female in the group, also experiences overeating related to boredom. This scenario provides an opportunity for one of the co-leaders to facilitate the discussion and another co-leader to self-disclose and participate more regarding his or her own eating experiences.

Leader 1:	Okay, so when you were all monitoring your eating last week, many of you recognized that you eat when you are bored. What are some ways that you might be able to deal with boredom other than eating?
Susan:	I don't know, maybe go running or something?
Leader 2:	Running is a good idea. How about you Phil?
Phil:	Well, I can't run—my knees are bad. I can't exercise at all.
Leader 1:	Well, it's important to remember that everyone is different.
Leader 2:	That is the truth. When I was younger and bored and wanted to eat, my mother used to always tell me to have a cookie! Now I try to drink a glass of water instead.
Susan to Leader 2:	You get bored and eat too? Wow!
Leader 2:	I sure do, Susan, and I have had to learn to do something else instead.
Maryanne:	You know, I've found that reading or doing something else with my hands is a good way to distract myself.
Phil:	I like gardening. Maybe I could give that a try.

Additionally, leaders may share other ideas with participants such as Wilson and Pike's (2001) successful progressive muscle relaxation suggestion as a means to postponing and preventing binge-eating behaviors among a population of clients with bulimia nervosa.

In addition to imparting information regarding healthy food intake, these sessions aim to promote incorporating exercise into daily living. The primary group leaders should invite at least two well-trained, certified nutritionists and yoga instructors from reputable local community or private businesses for these sessions. Visiting leaders should be able to provide information and group activities regarding appropriate nutrition needs and anaerobic and aerobic exercise as well as strength training and their benefits. For example, during the fifth session, all group members are invited to participate in a beginning level 30-minute yoga session. This activity is designed to teach family members basic yoga poses; it provides families with the chance to engage in a noncompetitive exercise program focusing on body competency rather than body appearance. Any of the family members (or families as a whole) can choose not to participate in the yoga session and can elect to participate in deep breathing or walking exercises instead.

Sessions 6 and 7: Facilitating Family Communication

Sessions 6 and 7 are dedicated to examining how familial communication patterns may be amplifing negative body esteem and maladaptive eating patterns. Many eating disorder treatment facilities utilize mealtime within the MFG sessions as a means of exploring family interactions in the presence of food (Dare & Eisler, 2000; Scholz & Asen, 2001). As a result, the sixth session of this program is designed to provide group leaders with an opportunity to observe within-family group communication styles during mealtimes. It is recommended that this occur in one of two formats, depending upon group needs. The group session may be held at an outside location, such as a local restaurant, or food may be brought into the location in which group is held. It is important that families be given options regarding food consumption. As a result, a restaurant that has a buffet may be beneficial, or leaders may bring in a diversity of foods. This freedom allows group leaders to witness food choices being made by members, as well as reactions and interactions between family members regarding those choices. Family members should sit together with group leaders observing familial interactions. For the last 30 minutes of this group, each family will meet with one of the group leaders in order to process this experience.

The following session allows for a continuation of the processing of family communication styles surrounding mealtimes, as well as

further exploration of family interactions. Fishbowl techniques, wherein a family enters the center of a circle and engages in conversation regarding the issues at hand while the rest of the families observe and comment on this interaction, can be useful in understanding family communication styles (Dare & Eisler, 2000).

A primary responsibility of the leaders in these sessions is to model and facilitate direct member-to-member contact both within and across families. When direct member-to-member contact across families occurs, Scholz and Asen (2001) describe surrogate parenting as positive consequence of the multiple family group. Surrogate parenting occurs when an adolescent bonds to adults in another adolescent's family. Through surrogate parenting, an adolescent may learn to trust and relate to others across generational boundaries and, in turn, learn to interact more positively with their own parents (Scholz & Asen). Additionally, it is imperative that leaders facilitate the process of linking common experiences of members and families, thereby allowing members further insight into their own experiences understanding others' concerns (Colahan & Robinson, 2002). For example, Leslie's family has been in the center of the fishbowl, discussing how Leslie feels as though her mother, Debbie, doesn' see her as anything other than her body. Judy, Shannon's mother, becomes tearful during this interchange.

Leader: Judy, I can see you're experiencing some powerful emotions right now.

Judy: I was just remembering myself with my father when I was younger. He was always so focused on how my sisters and I looked. It was like he was never able to recognize anything we did—he could just see that we were slightly overweight.

Leslie: That's exactly how I feel! It's like nothing I do is good enough because of how I look. I work so hard in school Mom, and you never notice; you never notice anything I do, except when I gain weight.

Leader: Debbie, how does it feel to sit there and see Judy upset over an experience similar to what your daughter is feeling?

Through further discussion, Debbie reveals that her concern for her daughter's weight is rooted in her fear of her health in a family with a history of diabetes and hypertension. However, through Judy's disclosure of the lasting effects of a similar experience with her father, Debbie realizes that her concern for her daughter's health, though warranted, is not worthy of ignoring her daughter's successes in other venues.

Overall, these sessions aim to develop family understanding of their current communication styles and how these means of interaction may have maladaptive effects on adolescent body esteem and/or dietary

habits. These sessions provide the foundation for making positive changes within the family and laying the groundwork for the subsequent sessions regarding teasing and negative evaluation of body shape and size within the family.

Session 8: Dealing with Teasing and Harassment

The goal of the eighth session is to enhance individual coping skills to combat against teasing, decrease negative evaluations regarding weight and shape by the family, and educate members regarding the detrimental effects of these comments. Because family members, specifically siblings, are often perpetrators of teasing about body shape and size, active engagement of the entire family in this session is of utmost importance. Due to the sensitive nature of this topic, leaders should begin the session by breaking the group into smaller subgroups based on family role. Specific attention should be given to adolescents' reservations regarding disclosing the effects of familial teasing on their experience of body dissatisfaction. Leaders should strive to instill a sense of empowerment within the adolescents prior to reconvening the full group processing of this topic. Leaders working with the other subgroups should focus on facilitating a discussion regarding the psychological impact of teasing and harassment.

Cognitive-behavioral methods, such as cognitive restructuring and the promotion of coping skills, should be employed in this session to reduce the negative effects of evaluative statements and augment the adolescent's ability to cope with these stressors. For many adolescent females, teasing may take the form of sexual harassment (Piran, 1999). Adolescents and their families should be taught tools to address interactions such as these that can be hurtful. Role-playing situations in which the adolescents and their families may experience sexual harassment and/or teasing may provide adolescents with behavioral skills to positively cope with future experiences. All family members should be encouraged to discuss personal experiences of teasing and harassment. For example, Joe, Shannon's father, has been silent for much of the session. Noticing this, one of the leaders asks Joe what he is currently experiencing.

Leader: Joe, I've noticed you haven't been contributing much tonight. Tell me what's going on for you right now.
Joe: This whole discussion of teasing is just hard for me. I was a big guy when I was little, and I can just remember being continuously attacked by some of the kids who were athletic and on the sport teams for my size.
Leader 2: It sounds like that was a pretty difficult experience for you.

Joe: It really was. I promised myself after I got into shape that I would never let my kids get to the point that they might be teased by other kids. So when things started getting hard for Shannon at school with some of the other girls, I figured that an easy way to deal with it would be by getting her on a diet—when I lost weight, the kids stopped harassing me. Same thing with Pete, when he started getting teased by some of the other boys, I signed him up for football.

Pete: But I always wanted to play football Dad. I'm the defensive tackle—being big is a good thing!

Carrie: But Dad, I'm not you or Pete. Every time you tell me I shouldn't eat something, or that my clothes are too revealing, it makes me feel like I'm just a huge blob.

Pete: But Shannon, come on, you have to admit—you could stand to lose a few pounds. In this family, we all could.

At this point, leaders may again decide to break the group down for intentional subgroup discussions regarding within-family teasing and its consequences. Leaders should facilitate a discussion regarding the impact of how seemingly harmless commentary regarding an individual's shape or size, as well as the overt statements like Pete's, might negatively impact an individual's body esteem. Family members who are more prone to being the perpetrators of teasing within the family context should be challenged to explore how teasing has impacted them—regardless of teasing being body or nonbody related.

Following the subgroup activities, the group may again come together to review skills such as positive self-talk as a means of coping with teasing and harassment, as well as developing appropriate responses Carrie can use if she is teased by others. Finally, group leaders should remain cognizant that this is the second-to-last session of the MFPPG and, as a result, begin the termination process with the group (Corey & Corey, 2002).

Session 9: Saying Goodbye

The final session should be dedicated to addressing any last-minute anxieties regarding the ending of the group, as well as encouraging members to continue to understand, explore, and develop the gains they experienced over the course of the nine weeks. This session should provide group members with an opportunity to say goodbye to each other. Families may chose to write letters to the other families regarding the role that family played in facilitating their growth. Additionally, it is imperative to process group termination in a full-group setting in order for members to experience closure (Corey & Corey, 2002). For example, Phil, who has been silent most of the session, suddenly speaks out.

Phil: I don't know what I'm going to do without this group. These last few weeks have been so great for me and our family. For so long, I've been concerned about my relationship with Susan, and for the first time we're actually getting along. I'm so worried that we'll leave here and go right back to our old ways.
Debbie: I know what you mean. I've finally begun to really take an active part in Leslie's school life, going to her plays and concerts.
Leader: All right, let's talk about some things you all can do to make sure you all stay on track.

Leaders then reinforce and review the skills learned throughout the course of the nine week sessions. Group leaders should be cognizant of whether or not families would benefit from counseling and offer referrals as necessary. Members should also take the time to personally process group, family, and individual growth by re-examining their first-session goals and the progress they made. Group members should then be asked to complete an evaluation of the program. The evaluation should include questions regarding both personal and family changes as a result of the group.

To ensure the maintenance of gains, group leaders may hold follow-up sessions three or six months following the conclusion of the group. Additionally, it should be noted that many adolescent females will continuously be faced with body and eating-related issues throughout high school (Davis et al., 2004; Jones, 2004; Phelps et al., 2000). As such, group leaders may suggest that group members participate in annual booster sessions for optimal success.

DISCUSSION AND OPPORTUNITIES FOR FUTURE EXPLORATION

If implemented successfully, the MFPPG format for prevention of disordered eating in adolescent females has the potential to profoundly impact young girls at a pivotal point in their lives as well as present and future of group counseling. Though largely psychoeducational in nature, the MFPPG—like many successful groups—may allow for the fostering of many of Yalom's curative factors through its emphasis on group member interaction, as encouraged by the NSVSM (Yalom, 2005). Of primary significance to this particular group are universality and the instillation of hope. As Scholz and Asen (2001) note, many families with an adolescent who is experiencing significant disordered eating feel isolated. By providing both the adolescents and their larger family systems with a venue to vocalize their concerns regarding their bodies and their relationship

with food, the multiple family group format allows members to recognize that they are not alone in their concerns (Scholz & Asen). In addition, there is the possibility for recapitulation of family dynamics (Yalom) in any group that involves multiple families and interactions.

Due to its psychoeducational nature, another important aspect of this group is the dissemination of information from leader to group members. Accurate factual information regarding proper health practices, as well as the teaching of positive coping skills through modeling and training, may strongly influence the adolescents' ability to deal with future stressors (Phelps et al., 2000). There are numerous leadership caveats that may exist when implementing this method with families. For example, the group leaders' teaching and counseling skill levels in relation to the use of family work in a group-setting should be given a great deal of consideration. This MFPPG experience is a multilayered group that involves a great deal of planning and educational skills; however, in such an environment leaders can never be fully prepared for all of the within-family and between-family dynamics that may occur in the larger group context. Fortunately, well-trained and experienced co-leaders can balance these skills with one another and allow for multiple areas of expertise to emerge. Finally, through communication workshops as well as weekly group member interaction and modeling (Yalom, 2005), it is anticipated that members will begin to adopt more effective communication styles both at home and in larger social interactions (Yalom). Interestingly, this group affords leaders and members the unique position of addressing each of the significant predisordered eating concerns facing female adolescents: sociocultural influences, body dissatisfaction associated with pubertal changes and restrictive eating, teasing/harassment regarding weight and shape, and family modeling and influences. Each of the MFPPG's nine sessions outlined focuses on one or more of these negatively influential concerns.

While this MFPPG approach is designed to target at-risk adolescent females' family contexts, larger systemic changes are still necessary for enhanced prevention of disordered eating. Empirical evaluation of this prevention group's efficacy is still necessary; however, its potential is promising by providing adolescent females with consistent messages regarding healthy body image, eating, exercise, and communication styles. The inclusion of the family in this program is intended for support and to allow for the maintenance of gains at follow-up, and, as such, booster sessions at six-month and one-year intervals are recommended. In addition, with students' permission, school counselors can be asked to follow up as well. Successful programming on the school level needs to be developed in order to

continue to promote systemic change and increase awareness of the prevalence and severity of disordered eating among America's youth. Indeed, the counseling profession as a whole has an interest in the organizational and societal systemic changes that need to occur to combat all adolescents' propensities toward disorder eating. MFPPGs such as that presented here allows for counselors to promote systemic change within families and communities.

As the counseling profession continues to move toward the implementation of group counseling as a primary means of providing services to clients, the MFPPG approach offers yet another option for mental health counselors. This particular approach to group counseling allows for the influence on multiple clients of varying ages and backgrounds. It also allows for the integration of empirically sound family counseling techniques as well as group and individual techniques in a psychoeducational setting. Finally, it provides an exciting opportunity for counseling theory and practice development in the areas of prevention groups, multiple family groups, family dynamics, and adolescent disordered eating.

Multiple family groups for adolescent disordered eating hit closer to home by including those who are most likely the closest to the at-risk adolescents—their families. In addition, proactive early prevention is recognized as a powerful force in deterring more serious eating disorders later in life. Early prevention, united with the power of psychoeducation in a group counseling setting and direct family involvement, may be one of the most compelling approaches for working with adolescents at risk for disordered eating before they require more serious counseling interventions and/or hospitalization. This innovative MFPPG approach will generate a rewarding clinical group practice for counselors and a compelling area of future group work research.

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