Family-Based Treatment for Adolescent Eating Disorders

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WWW.
Outline

1. Brief review of evidence supporting family therapy for adolescent eating disorders
2. Description of fundamental principles of treatment using the family empowerment model
3. Illustration of key therapeutic procedures
4. Discussion
Part I

Background and Research
Outcome Studies
Controlled & Uncontrolled Psychotherapy Trials for Adolescent AN

Uncontrolled Studies
- Minuchin et al (1978)
- Dare (1983)
- Martin (1984)
- Mayer (1994)
- Herscovici & Bay (1996)
- Le Grange & Gelman (1998)
- Lock & Le Grange (2001)
- Wallin & Kronwall (2002)
- Le Grange et al (2005)

Controlled Trials
- Russell et al (1987)
  - Eisler et al (1997)
- Crisp et al (1991)
- Le Grange et al (1992)
  - Eisler et al (2007)
- Robin et al (1994)
  - Le Grange, Lock et al (2011)
# Observed Partial and Full Remission by Treatment

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- **Not remitted**
- **Partial remission**
- **Full remission**
FBT for BN (Le Grange et al 2007)

![Graph showing remission rates for FBT-BN and SPT with p-values for comparison](image)

- Remission rates are compared between FBT-BN and SPT.
- The graph shows percent remission at baseline, post-treatment, and 6-month follow-up.
- Statistically significant differences are indicated with p-values: p = .049 for FBT-BN compared to baseline, and p = .050 for SPT compared to baseline.

This graph illustrates the effectiveness of FBT-BN compared to SPT in achieving remission rates.
Conclusions of Review

- FBT is feasible, acceptable, and effective for adolescent AN
- FBT MAY be superior to individual treatments for adolescent AN
- FBT-BN is superior to non-specific psychological treatment in adolescent BN
- FBT-BN is equivalent to CBT/GSH in adolescent BN
- FBT-BN is acceptable to younger BN adolescents, may be less so for older ones
Part 2

Therapeutic Assumptions and Processes in Family-Based Treatment for Adolescent Eating Disorders
“In view of the undoubted psychological aspects (of the disorder), it would be equally regrettable to ignore or misinterpret the patient’s psychological surroundings.”

“None should be surprised to note that I always consider the morbid state of the hysterical patient side by side with the preoccupations of her relatives.”

Charles Lasegue, 1873
“The patients should be fed at regular intervals, and surrounded by persons who would have moral control over them; relatives and friends being generally the worst attendants.”

Sir William Gull, 1873
“It is necessary to separate both children and adults from their father and mother, whose influence, as experience teaches, is particularly pernicious”

Charcot, 1889
Fundamental Assumptions of the Maudsley Approach

- Agnostic view of cause of illness (Parents are not to blame)
- Initial focus on symptoms (Pragmatic)
- Parents are responsible for weight restoration (Empowerment)
- Non authoritarian therapeutic stance (Joining)
- Separation of child and illness (Respect for adolescent)
Agnostic

- No blame (but does not mean no responsibility)
- No guilt (but does not mean no anxiety)
- Therapist does not pathologize (either directly or indirectly)
- Do not look for cause of illness (etiology is not the focus of treatment)
Strategies to Maintaining Agnosticism

- Do not pathologize (if there is some pathology, work with it)
- Practice forgetting (what you think you know)
- Do not theorize (work with what’s in front of you)
- Work with and encourage strengths, not weaknesses
- Use supervision to identify problems in maintaining perspective
- Intervene with serious pathology (abuse, neglect) supportively but immediately
"I do not consider it an insult, but rather a compliment to be called an agnostic. I do not pretend to know where many ignorant men are sure -- that is all that agnosticism means." - Clarence Darrow

"Extraordinary claims require extraordinary evidence."
- Carl Sagan

“In all affairs it’s a healthy thing now and then to hang a question mark on the things you have long taken for granted.” - Bertrand Russell

“If you see a man approaching you with the obvious intent of doing you good, you should run for your life.” - Henry David Thoreau

“When I told the people of Northern Ireland that I was an atheist, a woman in the audience stood up and said, "Yes, but is it the God of the Catholics or the God of the Protestants in whom you don't believe?“ - Quentin Crisp
Initial Symptom Focus

- Emphasis is first on behavioral change (eating normally and not binge eating or purging)
- History-taking focuses on symptom development
- Delay of other issues until patient is less behaviorally and psychologically involved with AN
- No direct cognitive focus with adolescent
Strategies for Remaining Focused

- Use weight chart
- Avoid “other issues” e.g. etiology, causation
- Strategy to limit medical aspect of AN (both as maintaining factor—glucose on the brain—and sequelae of starvation
- Keep tasks of session “in mind”
Empowerment

- Family is a RESOURCE for helping patient
- Most families CAN help patient
- Family has SKILLS to bring to the treatment
- Therapist leverages parental skills and relationships to bring about change (efficiency)
Strategies for Empowerment

- Listening, not telling
- Asking, not telling
- Suggestions, not orders
- Information, not instructions
- Support, not criticism
- Focus on Positive feedback (regard)
- Use examples
- Advice, not prescriptions
Therapeutic Stance

- Serves as expert consultant
- Does not control parents or patient
- Therapist is active in treatment
- Most decisions are left to parents
- Supports therapeutic autonomy for parents
Being a good consultant

- Know the medical and psychological literature on AN
- Know how adolescents with AN “think”
- Set specific goals about changing eating and weight loss behaviors with family
- Involve the entire family
- Don’t overwhelm with information
- Help family anticipate process (j curve)
- Remember families will want you to tell them what to do and when you do they will fail and blame you
Externalization of Illness

- The adolescent is not to blame
- No pathologizing of patient (not regressed, immature, but rather ill)
- Respects adolescent status (without negotiating with BN)
- Supports increased autonomy with recovery for BN
Strategies for Externalization

- Disease model (cancer)
- Possession model (spider, alien)
- Intellectual model (Venn diagram)
- Scientific model (genetics)
- Psychological model (behavioral regression)
- Treatment Process (sand hill, Venn diagram, j-curve)
Effect of these tenets

- Highly focused, staged treatment
- Emphasis on behavioral recovery rather than insight and understanding or cognitive change
- This approach might indirectly improve family functioning
- Supports gradual increased independence from therapy
Prior to starting treatment

- Patient is medically stable for outpatient treatment
- Diagnostic interviews are completed and patient is appropriate for treatment
- Parents are reasonable candidates to help (live with the patient, not psychotic or substance dependent, no abuse)
- Parents agree to bring the entire family for treatment
- Nutritional advice is not provided directly to the patient
What is the FBT

- Outpatient disordered eating program
- ~ 10-20 outpatient family sessions over 6-12 months
- Puts the PARENTS in charge of restoring normal eating patterns (appropriate control, ultimately relinquished), contrary to traditional clinical recommendation of “parentectomy”
Treatment Style and Format

- Therapist balances an active stance (mobilizing parental anxiety) with deference to the parents’ judgment (empowerment)

- FBT has been studied in separated and conjoint formats (Separated tx perhaps better for high EE fam’s)

- FBT has been studies in short- and long-term format (six vs 12 months)
Three Phases Of Treatment

• Phase I
  - Parents restore their child’s weight

• Phase II
  - Transfer control back to the adolescent

• Phase III
  - Adolescent development issues
  - Termination
Phase 1: Parents Take Control of Eating and Weight
Session One

**Goals:**
- Engage the family
- Obtain a history of how AN affects family
- Assess family functioning (coalitions, conflicts)
- Reduce parental blame

**Interventions Include:**
- Greeting family in sincere but grave manner
- Separating illness from patient
- Orchestrating intense scene concerning AN
- Charging parents with the task of refeeding
Session Two

• **Goals:**
  - Assess family structure as it may affect ability of parents to refeed patient
  - Provide opportunity for parents to successfully feed patient
  - Assess family process during eating

• **Interventions Include:**
  - One more bite
  - Aligning patient with siblings for support
• **Goals:**
  - Keep the family focused on the AN
  - Help the parents take charge of child’s eating
  - Mobilize sibling support for patient

• **Interventions Include:**
  - Start of each session, weigh pt and inquire if s/he needs help raising issues
  - Continue refeeding focus, modification of criticism toward pt, externalization of illness
Phase II
Help Adolescent Eat Independently

• **Guidelines for transition to Phase II:**
  • Weight is at a minimum of ~90% IBW
  • Patient eats without significant struggle
  • Parents demonstrate their empowerment to manage illness
Phase II cont.

**Goals:**
- Maintain parental management until pt can gain wt independently
- Transfer food/weight control to adolescent
- Explore developmental issues relative to AN

**Interventions Include:**
- Assist parents in navigating return of control
- Continue to highlight differences between the adolescent’s own needs and those of AN
- Closing sessions with positive support
Phase III
Adolescent Issues and Termination

- **Assessing Readiness:**
  - Symptoms have dissipated (weight > 90% IBW), but some shape and weight concerns may remain

- **Goals:**
  - Revise parent-child relationship in accordance with remission of AN
  - Review and problem-solve re adolescent development
  - Terminate treatment
Phase III cont.

- **Interventions Include:**
  - Review normal adolescent development; establish that pt is back on normal trajectory in all domains
  - Model problem-solving behavior
  - Check parents relationship as a couple
  - Encourage fear of relapse; plan
  - Terminate
Specific Challenges in FBT for BN

- Secretiveness (shame and guilt) of BN
- Comorbidity and BN
- Heterogeneity of BN
  - Family status/SES
  - Cultural background
- Developmental stage of BN adolescents
How is FBT different for BN?

- Treatment is more collaborative
- Emphasis on regulating food intake, and curtailing binge/purge behavior

Family Meal in BN
- Helping adolescent eat regular meal
- Includes food that typically trigger binge
- Explore adolescent’s feelings around urges to binge
Current Treatment Studies

- FBT-BN vs CBT vs SPT for adolescent BN (co(NIMH))
- Adaptive FBT for adolescent AN (NIMH)
- FBT-Y for young adults with AN (NIMH)
- FBT vs PFT for adolescents AN (Baker Foundation)
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Selected References


