The Society for Clinical Child and Adolescent Psychology (SCCAP): Initiative for Dissemination of Evidence-based Treatments for Childhood and Adolescent Mental Health Problems

With additional support from Florida International University and The Children's Trust.

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Workshop

Rationale and Principle Interventions in Family-Based Treatment (FBT) for Adolescent Anorexia Nervosa

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Part 1 of 3

Outline of this Presentation

① Family-Based Treatment Model
② Evidence Base
③ Fundamental Assumptions
④ Three Phases of FBT
⑤ Closing Remarks and Discussion

① Family-Based Treatment Model

The Maudsley Approach

Family-Based Treatment for AN

- Hospitalization
- Traumatic
- Disempowers Parents

Family-Based Treatment

- **Developed at the Maudsley Hospital in London in the 1980s.**
- **Continues to be refined at Chicago, London, Melbourne, Mt Sinai, Stanford, Sydney and other centers.**
- **Takes key strategies or interventions from a variety of Schools of Family Therapy**
  - **Minuchin – Structural Family Therapy**
  - **Selvini-Palozzoli – Milan School**
  - **Haley – Strategic Family Therapy**
  - **White – Narrative Therapy**

Family-Based Treatment

- **Theoretically agnostic – no assumptions about the origin of the disorder, focus on what can be done.**
- **Parents are a resource with no blame directed to either the parents or the ill adolescent.**
- **Siblings play supportive role and protected from the job assigned to the parents.**

Suitability and Context

- **Appropriate for children and adolescents who are medically stable.**
- **Outpatient intervention designed to a) restore weight; and b) put adolescent development back on track.**
- **FBT is a team approach, i.e., primary therapist, pediatrician and child & adolescent psychiatrist.**
- **Brief hospitalization to resolve medical concerns.**

What does FBT look like?

Adolescent Anorexia Nervosa

Treatment Style

Parents in charge

- Appropriate control
- Ultimately relinquished

Therapist stance

- Active – mobilize anxiety
- Deference to parents

Adolescent Respect

- Developmental process
- Traditional treatment upside-down

Treatment Detail

Dose

- 6-12 months

Intensity

- 10-20 sessions

Format

- Conjoint
- Separated

Three Phases of FBT

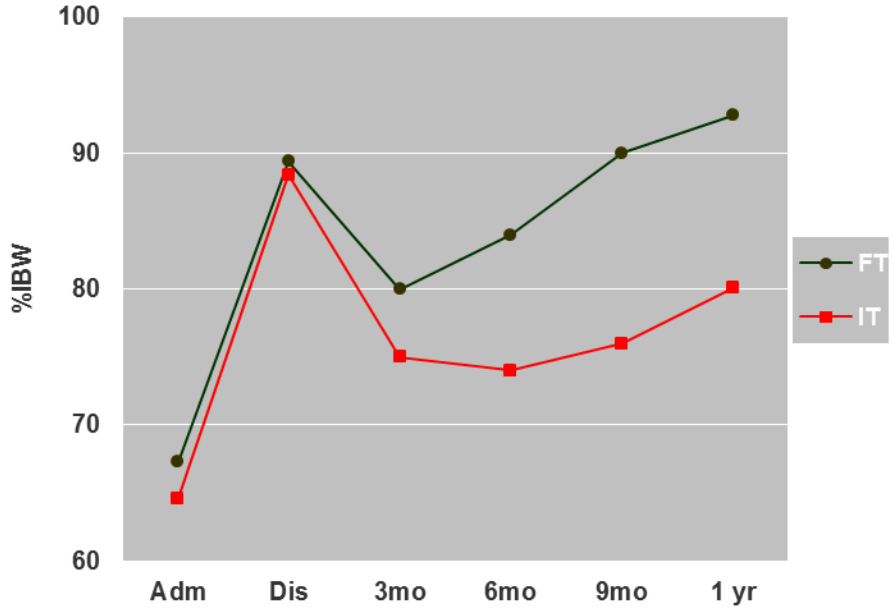
Phase 1 (Sessions 1-10)	• Parents in charge of weight restoration
Phase 2 (Sessions 11-16)	• Parents hand control over eating back to the adolescent
Phase 3 (Sessions 17-20)	• Discuss adolescent developmental issues

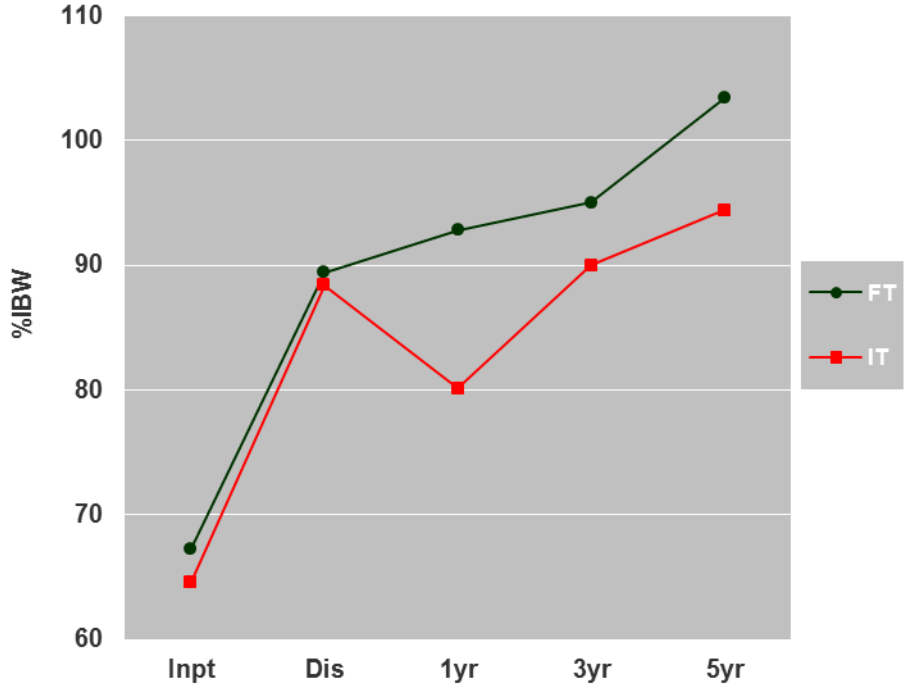
② FBT Evidence-Base

Adolescent Anorexia Nervosa

First Maudsley RCT (N=80) Subgr. 1 + 5 Yr FU

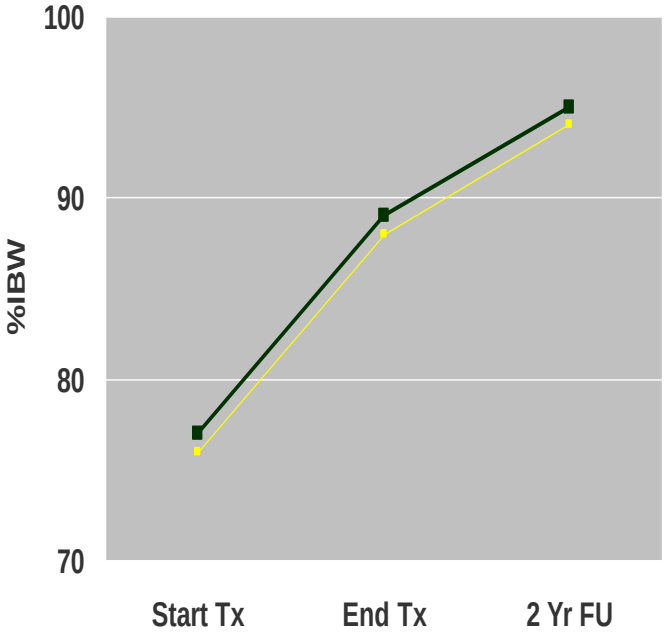
- FBT n=10
- Supportive therapy n=9
- 12 months Tx post hosp
- 5-year FU



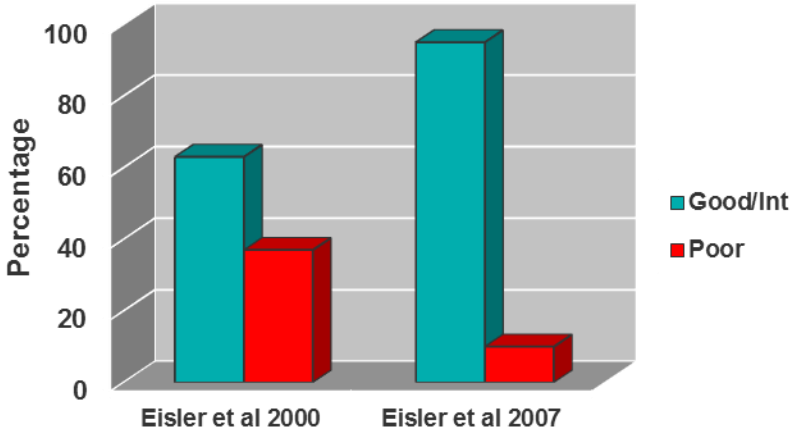


Russell, Szmukler, Dare, Eisler, *Arch Gen Psych,* 1987; Eisler, Dare, Russell, Szmukler, Le Grange, Dodge, *Arch Gen Psych,* 1997.

Second Maudsley RCT (N=58)



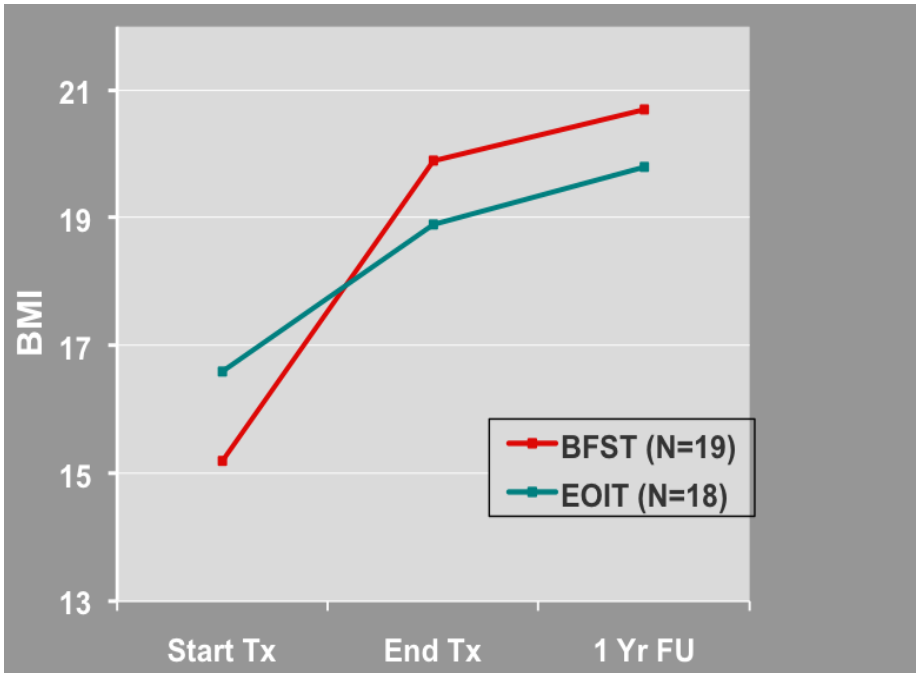
- **Pilot n=18**
- **Larger study n=40**
- **Conjoint FT (CFT)**
- **Separated FT (SFT)**
- **4-Year FU**

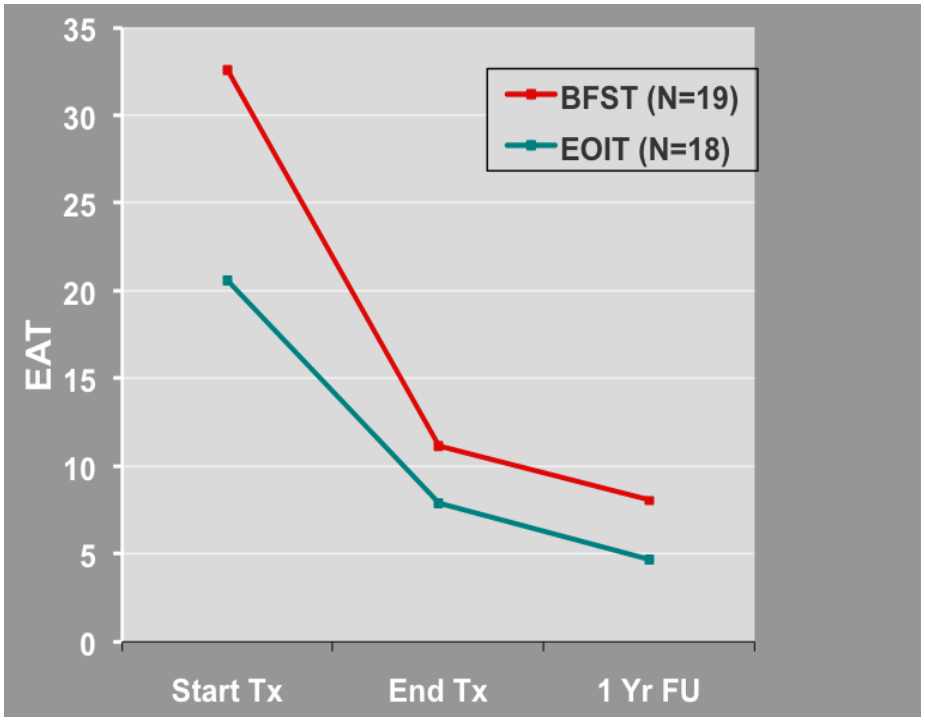


Le Grange, Eisler, Dare and Russell, *IJED,* 1992; Squire-Dehouck, 1993; Eisler, Dare, Hodes, Russell, Dodge & Le Grange, *J Child Psychol*, 2000.

First US Study Detroit RCT (N=37)

- BFST n=19
- EOIT n=18
- 12-18 months of Tx
- 1 year follow-up

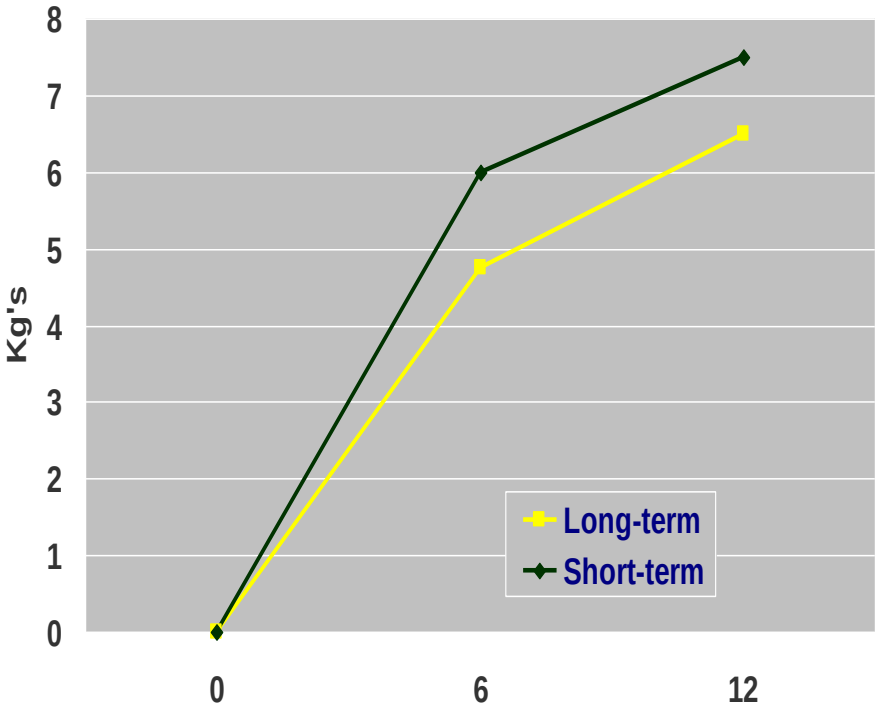


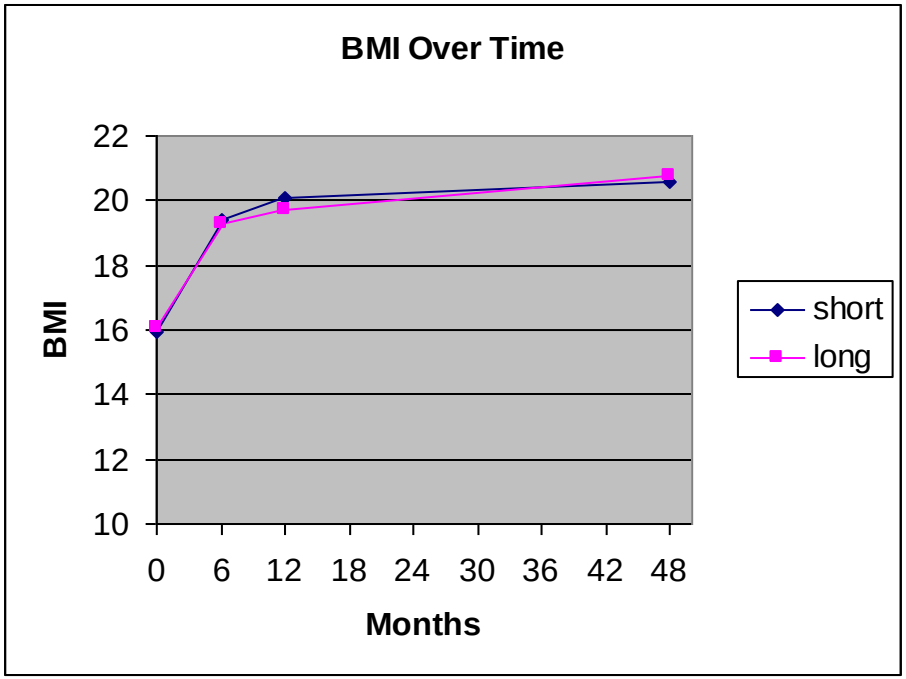


Robin, Siegel, Moye, Gilroy, Baker Dennis & Sikand, *JAACAP*, 1999.

Stanford Dosage Study (N=86)

- Long-term FBT
- Short-term FBT
- 12mo vs 6mo Tx
- 48mo FU



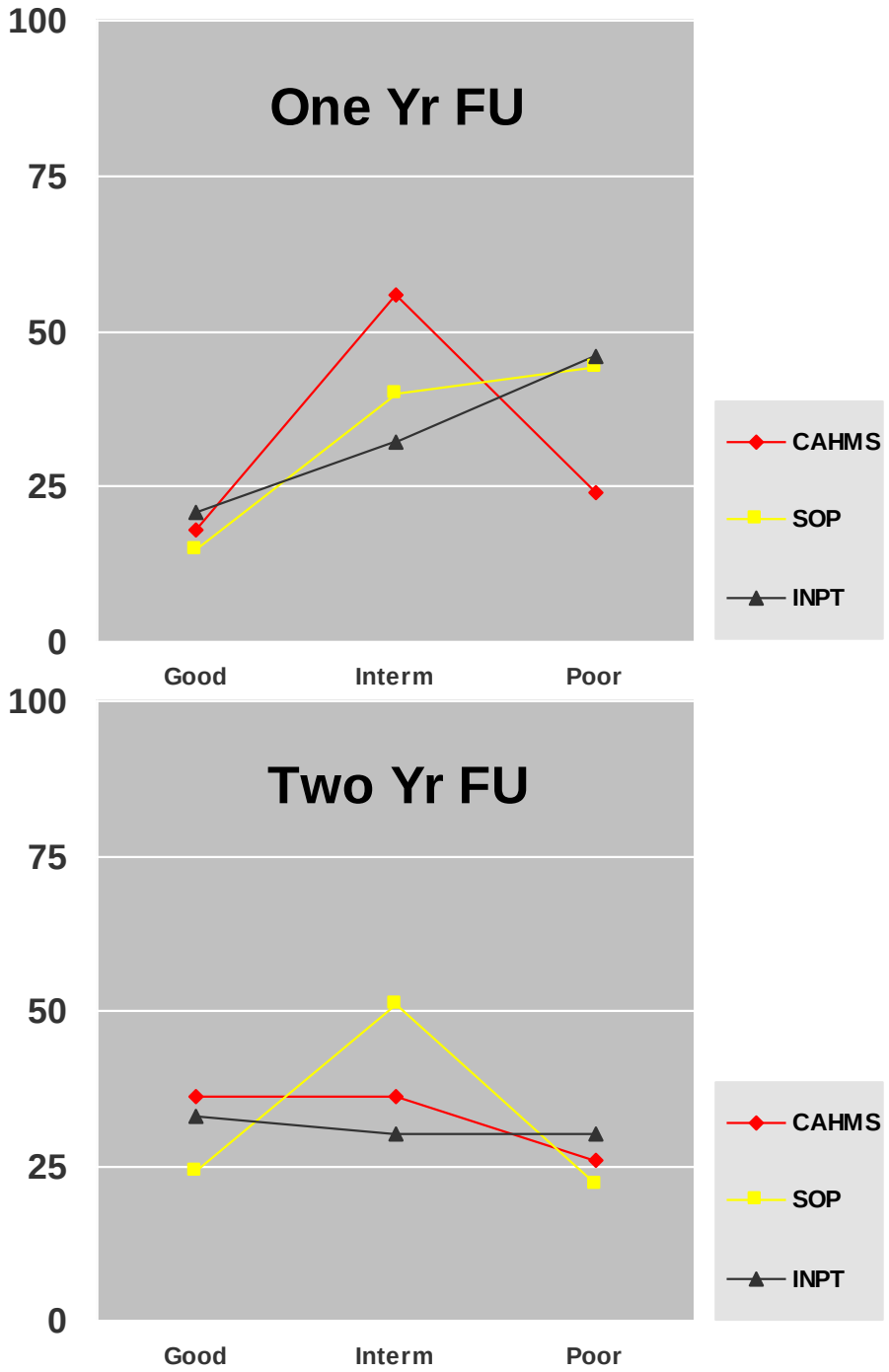


Lock, Agras, Bryson & Kraemer, *JAACAP*, 2005;
Lock, Couturier, Agras & Bryson, *JAACAP*, 2006.

Liverpool RCT (N=167)

- CAHMS n=55
- Specialized Outpt n=55
- Inpt treatment n=57
- One and two year FU

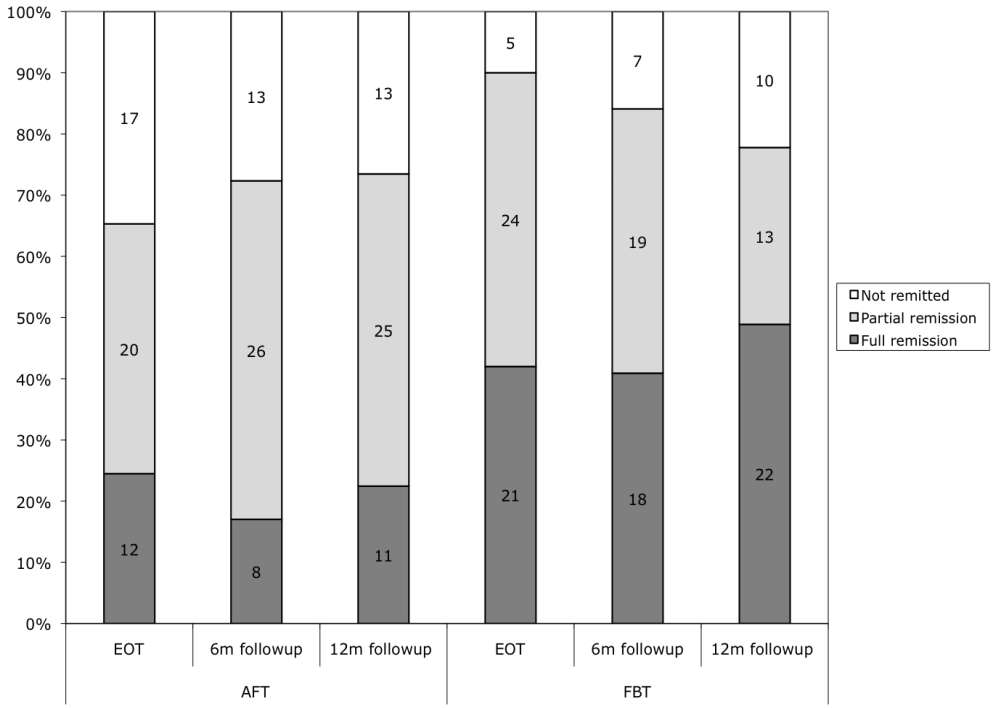
Gowers, Clark, Roberts, Griffiths, Edwards, Bryan, Smethurst, Byford & Barrett, *Br J Psych*, 2007.

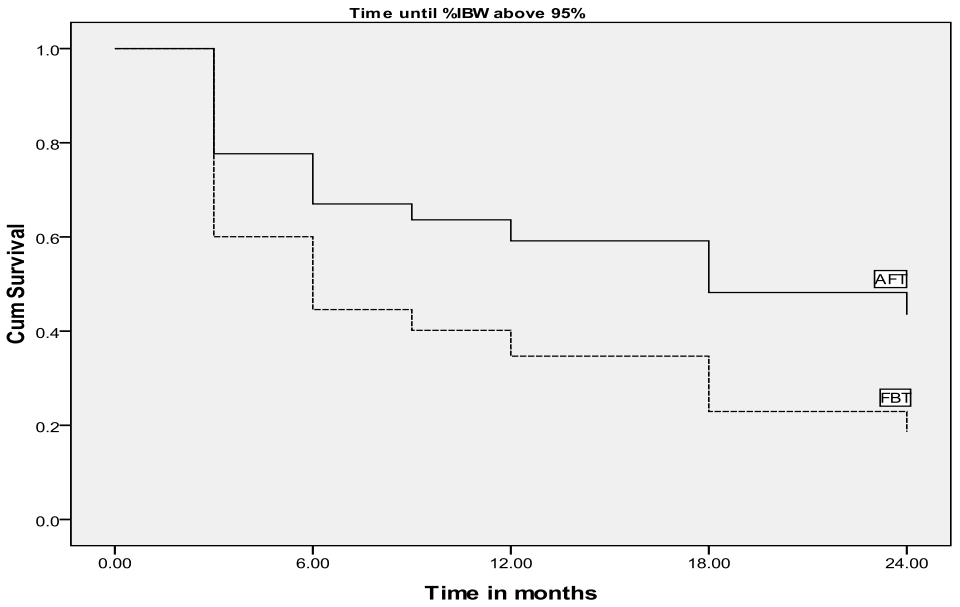


Chicago/Stanford RCT (N=121)

- FBT n=61
- AFT n=60
- Six and 12mo FU

Lock, Le Grange, Agras et al, *Arch Gen Psych*, 2010; Le Grange, Lock, Agras et al, *BRAT*, 2011.





Conclusions

- **FBT for children and adolescent AN patients with short duration illness is promising**
- **Most patients respond favorably after relatively few outpatient treatment sessions**
- **FBT as effective in brief form as in longer form; in conjoint form as in separated form**
- **The beneficial effects of FBT are sustained at 4-5 year follow-up**

Implications for AN

- **FBT should be the first line intervention for adolescents with AN who are medically fit for outpatient treatment**
- **Most patients respond favorably after relatively few treatment sessions if illness is recognized early on**
- **AFT could be a credible alternative for some patients**

Part 2 of 3

③ Fundamental Assumptions

Adolescent Anorexia Nervosa

Fundamental Assumptions

① Agnostic view of cause of illness (Parents nor adolescent are not to blame)

② Non authoritarian therapeutic stance (Joining with family)

③ Parents are responsible (Empowerment)

④ Externalization (Separation of child and illness)

⑤ Initial focus on symptoms (Pragmatic)

① 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 Maintain 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**

② 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
- Help family anticipate process (j curve)
- Don’t overwhelm with information
- Remember families will want you to tell them what to do and when you do they will fail and blame you
- Join the family in solving problems

③ Empowerment

- **Family is a RESOURCE for helping the patient**
- **Most families CAN help the 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**

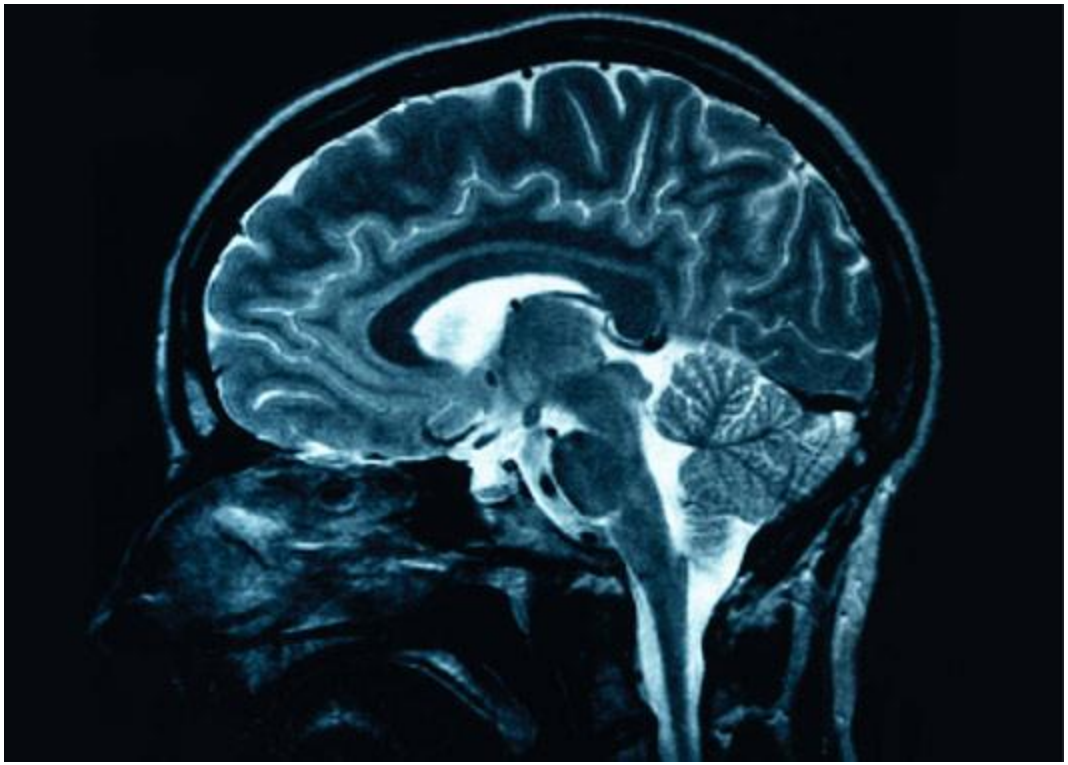
④ Externalization of Illness

- **The adolescent is not to blame**
- **No pathologizing of patient (not regressed, immature, but rather ill)**
- **Respects independent status**
- **Supports increased autonomy with recovery**

Strategies for Externalization

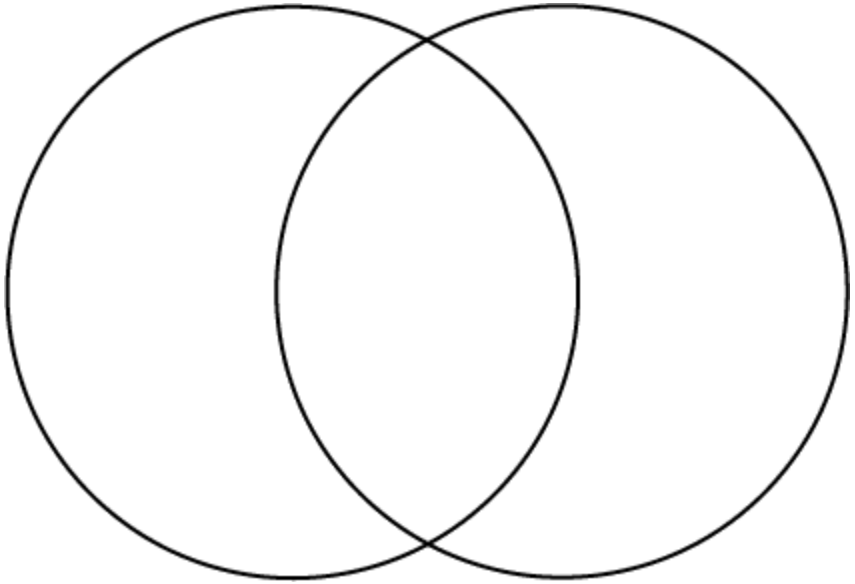
- **Disease model (cancer)**
- **Possession model (spider, alien)**
- **Intellectual model (Venn diagram)**
- **Scientific model (genetics)**
- **Psychological model (behavioral regression)**
- **Treatment Process (sand hill, Venn diagram, j-curve)**

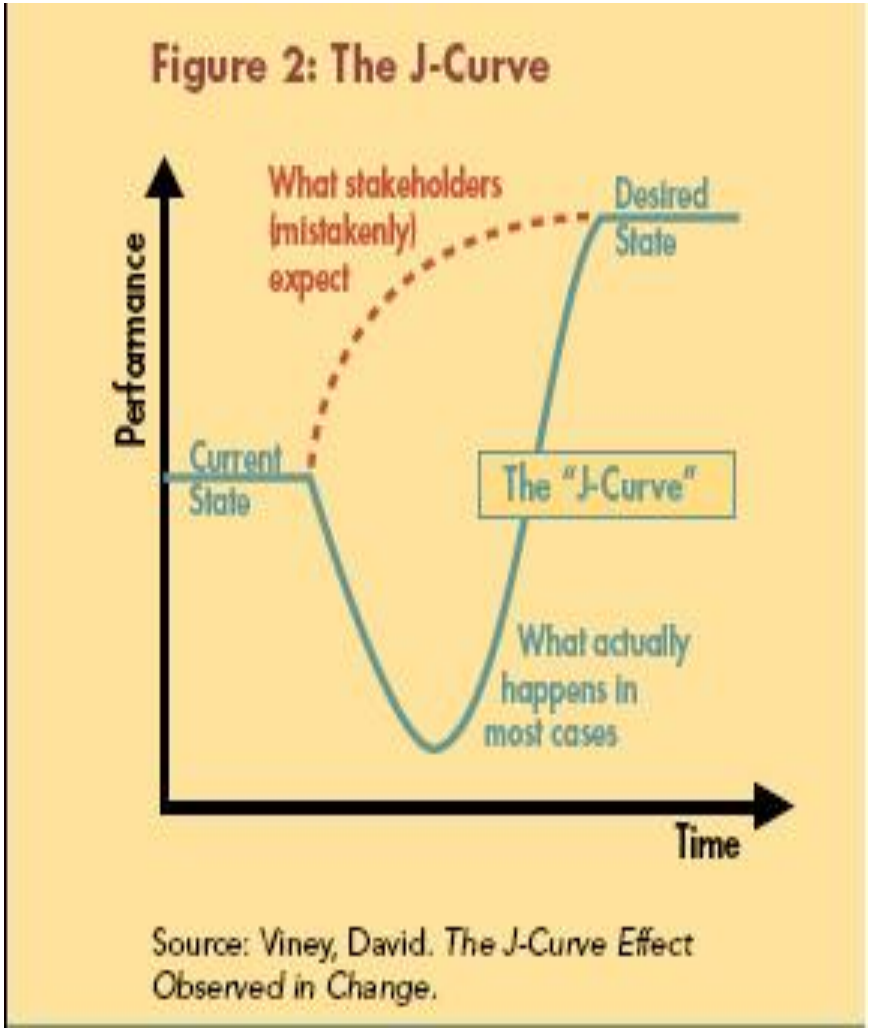
Cancer Model



Possession Model

Intellectual Model





⑤ 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**

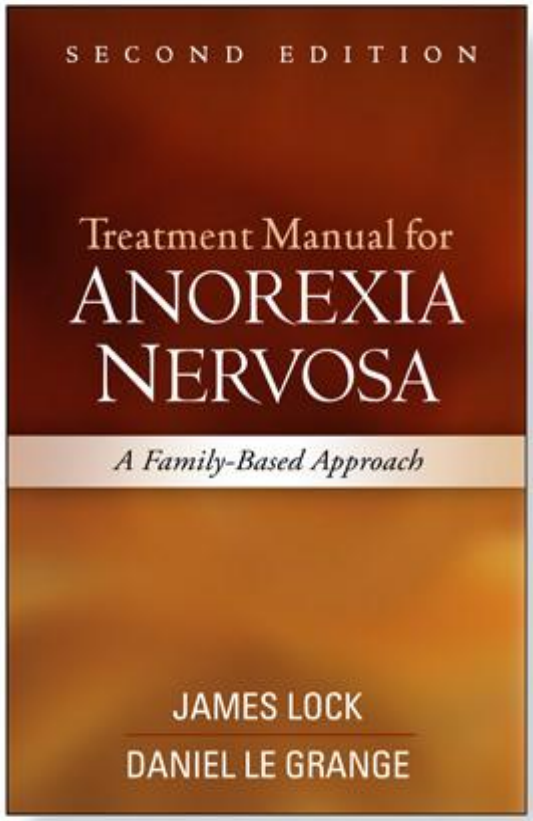
Strategies for Remaining Focused

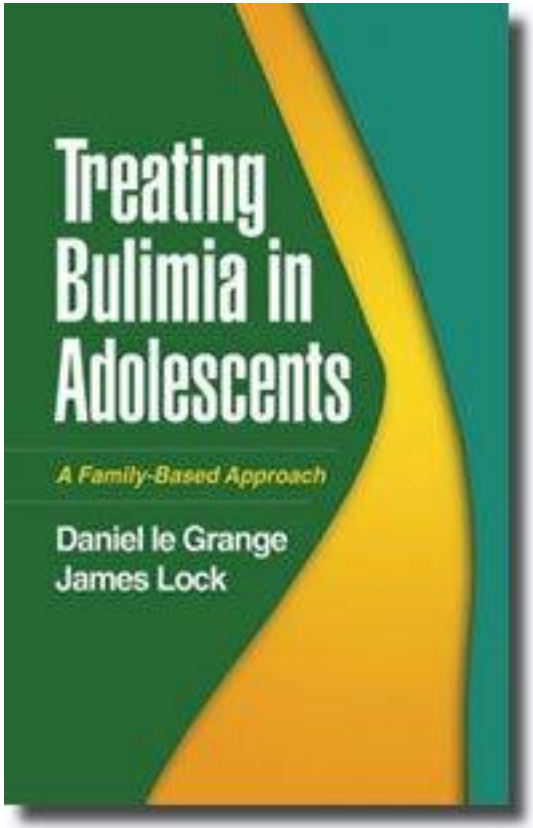
- **Use weight chart**
- **Avoid “other issues” e.g. etiology, causation**
- **Strategy to limit medical aspect of AN (as maintaining factor - glucose on the brain - and sequelae of starvation)**
- **Keep tasks of session “in mind”**

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**

4 Three Phases of Treatment





Part 3 of 3

What is FBT

- **Outpatient disordered eating program**
- **~ Twenty 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 (appropriately mobilize 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 studied in short- and long-term format (six vs 12 months)**

Prior to starting treatment

- **Patient medically stable for outpt 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**

Three Phases Of Treatment

- **Phase I (Sessions 1-10):**
  - Parents restore their child's weight
- **Phase II (Sessions 11-16):**
  - Transfer control back to the adolescent
- **Phase III (Sessions 17-20):**
  - Adolescent development issues
  - Termination

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**

Remainder of Phase I (Sessions 3-10)

- **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 (Sessions 11-16)
Help Adolescent Eat Independently

- **<u>Guidelines for transition to Phase II</u>:**
  - **Weight is at a minimum of ~90% IBW**
  - **Patient eats without significant struggle**
  - **Parents demonstrate their empowerment to manage illness**

Phase II continue

- **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 (Sessions 17-20)
Adolescent Issues

- **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 continue

- **<u>Interventions Include</u>:**
  - **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**

5 Closing Remarks

Resources, Current Studies and Conclusions

Resources

- **Dissemination of Family-Based Treatment**
  - **Clinician Manual for AN** (Lock & Le Grange, 2012)
  - **Clinician Manual for BN** (Le Grange & Lock, 2007)
  - **Parent Handbook** (Lock & Le Grange, 2007)
  - **Parent Case Book** (Alexander & Le Grange, 2009)
  - **Clinician Handbook** (Le Grange & Lock, 2011)
- **Training Institute for Child and Adolescent Eating Disorders, LLC**
  - **www.train2treat4ed.com**

For more information, please go to the main website and browse for workshops on this topic or check out our additional resources.

Additional Resources

Online resources:

1. Society of Clinical Child & Adolescent Psychology: http://effectivechildtherapy.com/sccap/
2. Training Institute for Child and Adolescent Eating Disorders, LLC: www.train2treat4ed.com

Books:

1. Le Grange, D., & Lock, J. (2007). *Treating Bulimia in Adolescents: A Family-Based Approach*. New York : Guilford Press.
2. Le Grange, D., & Lock, J. (Eds.) (2011). *Children and Adolescents with Eating Disorders: Handbook of Assessment and Treatment*. New York: Guilford Press.
3. Lock, J., Le Grange, D. (2012). Treatment Manual for Anorexia Nervosa: A Family-Based Approach, 2nd Edition. New York: Guilford Press.
4. Robin, A.L., & Le Grange, D. (2010). Treating adolescents with anorexia nervosa using behavioral family systems therapy. In J.R. Weisz and A.E. Kazdin (Eds.), *Evidence-based Psychotherapies for Children and Adolescents* (2nd Edition), (pp. 345-358). New York: Guilford Press.

Selected Peer-reviewed Journal Articles:

1. Le Grange, D., & Eisler, I. (2009). Family interventions in adolescent anorexia nervosa. *Child and Adolescent Psychiatric Clinics of North America, 18*, 159-173.
2. Le Grange, D., & Schmidt, U. (2005). The treatment of adolescents with bulimia nervosa. *Journal of Mental Health, 14*, 587-597.
3. Le Grange, D., Binford, R., & Loeb, K.L. (2005). Manualized family-based treatment for anorexia nervosa: A case series. *Journal of the American Academy of Child and Adolescent Psychiatry, 44,* 41-46.
4. Le Grange, D., Lock, J., Agras, W.S., Moye, A., Bryson, S., Jo, B., & Kraemer, H. (2012). Moderators and mediators of remission in family-based treatment and adolescent focused therapy for anorexia nervosa. *Behavior Research and Therapy*, 50, 85-92.
5. Lock, J., Le Grange, D., Agras, S., Bryson, S., & Booil, J. (2011). Randomized clinical trial comparing family-based treatment to adolescent focused individual therapy for adolescents with anorexia nervosa. *Archives of General Psychiatry, 67*, 1025-1032.

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