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

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Center for Children and Families

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

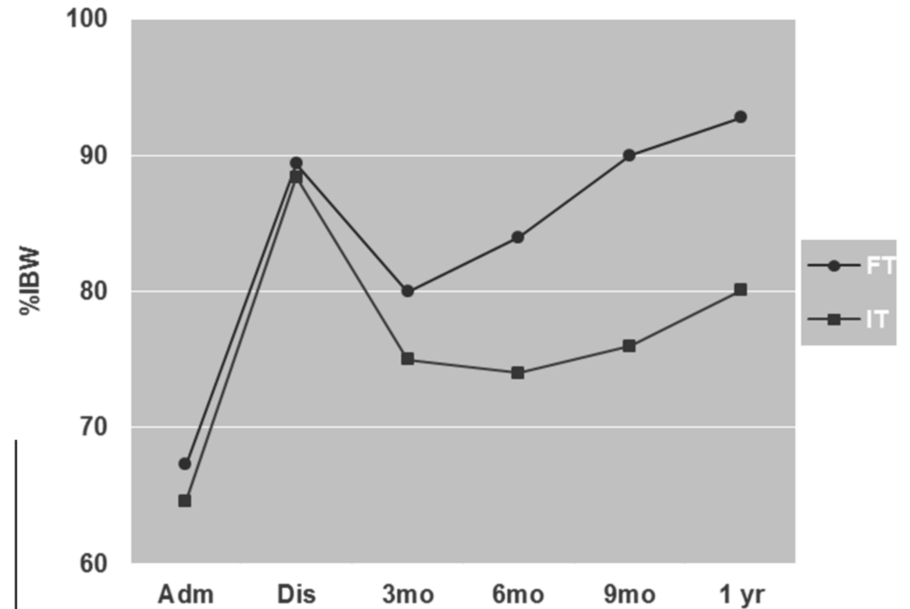
Phase	Description
Phase 1 (Sessions 1-10)	• Parents in charge of weight restoration
Phase 2 (Sessions 11-16)	• Parents hand control over eating back to the adolescent
Phase 3 (Sessions 17-20)	• Discuss adolescent developmental issues

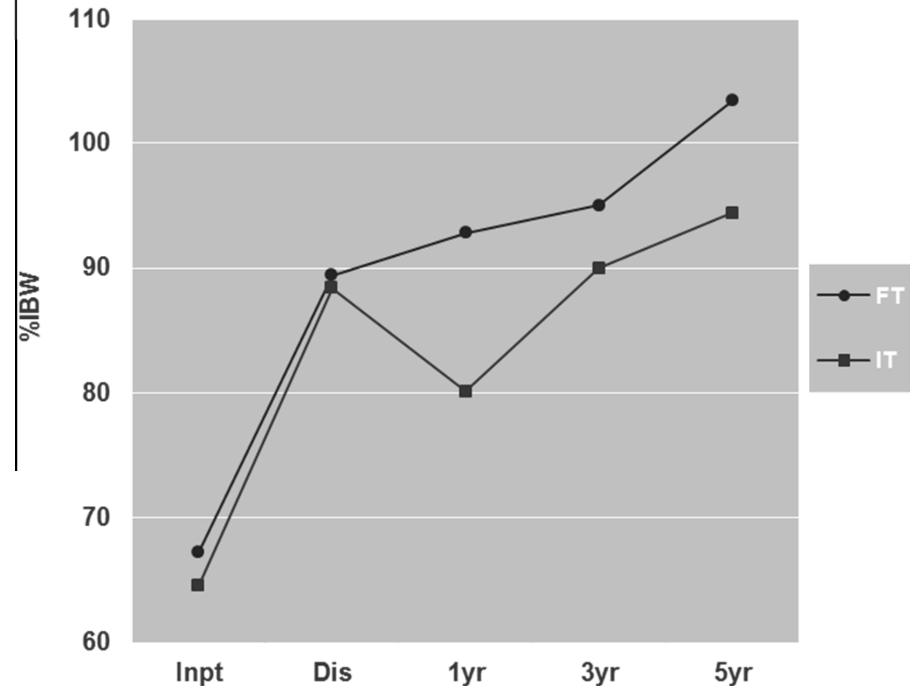
② FBT Evidence-Base

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



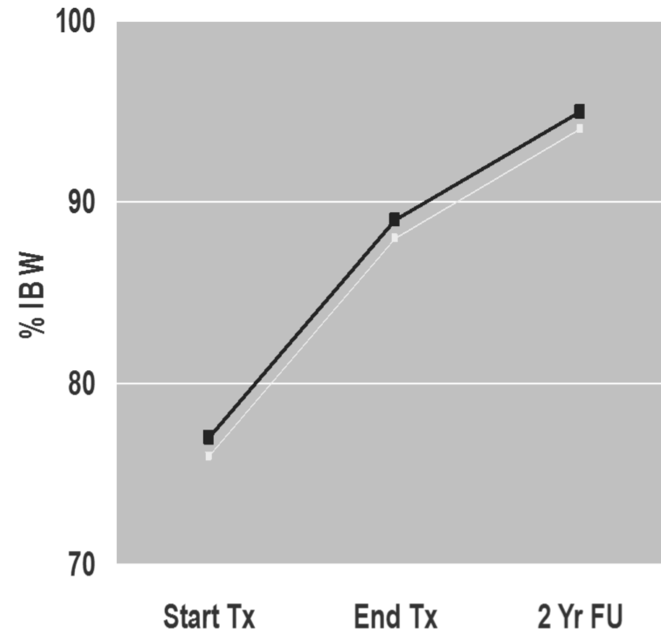


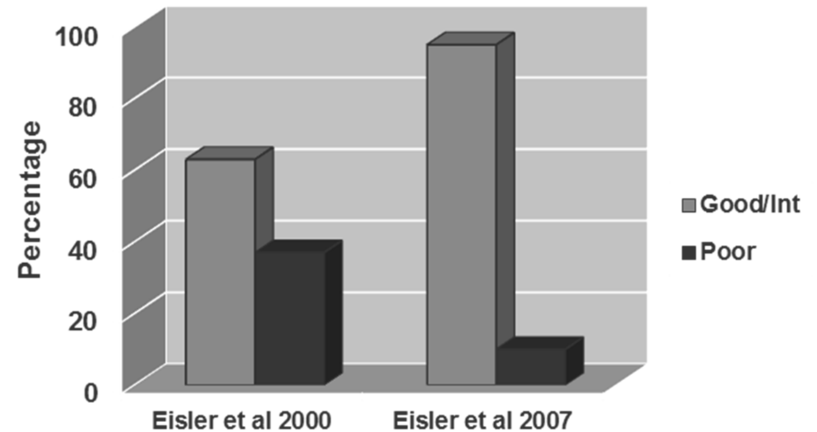
Russell, Szmukler, Dare, Eisler, *Arch Gen Psych,* 1987; Eisler, Dare, Russell, Szmukler, Le Grange, Dodge, *Arch Gen Psych,* 1997.

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.

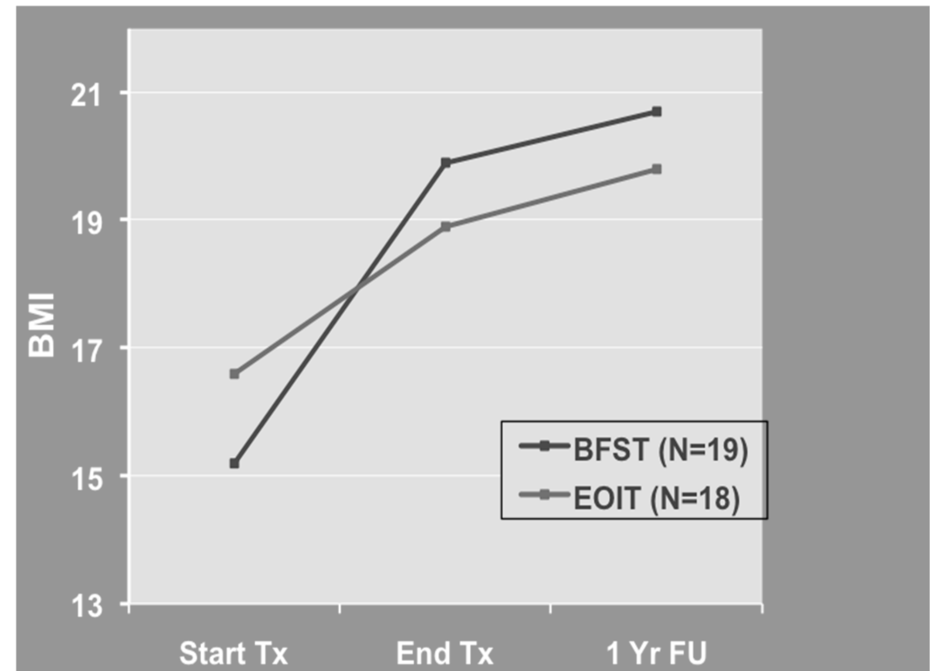


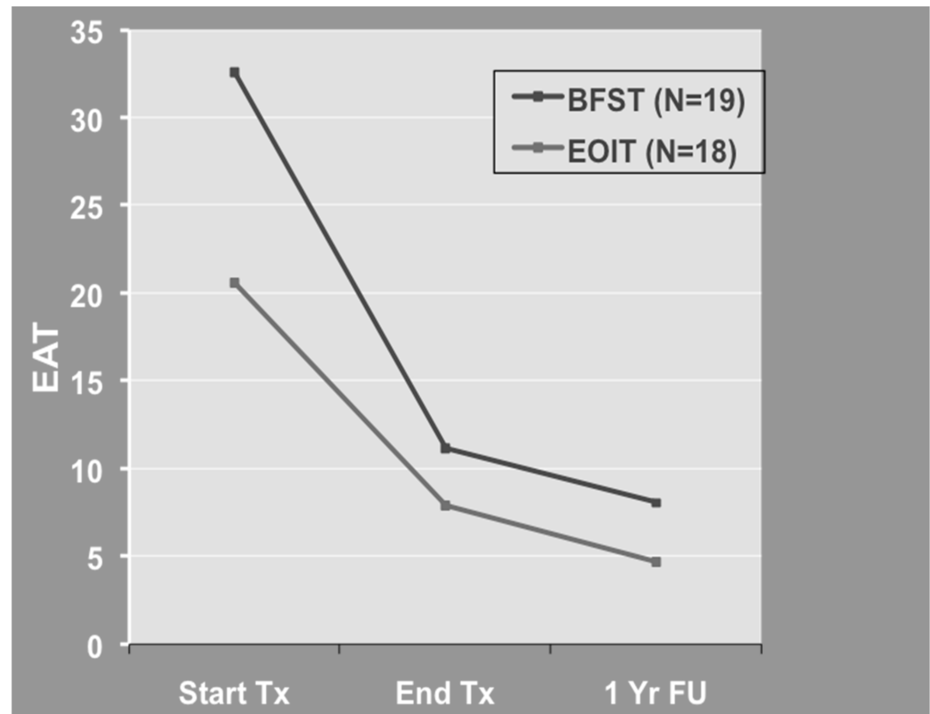


First US Study Detroit RCT (N=37)

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

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

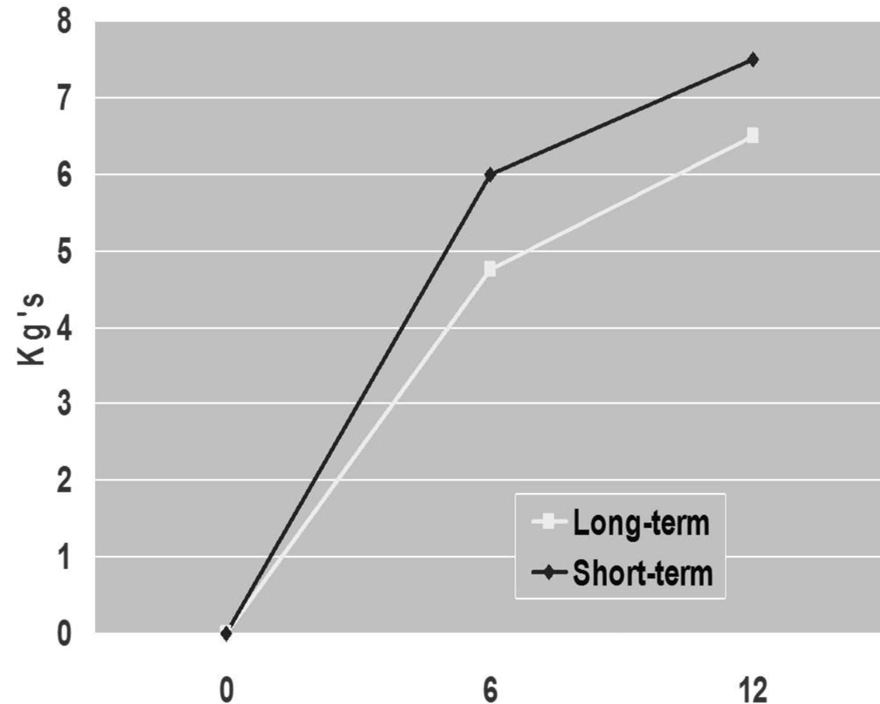


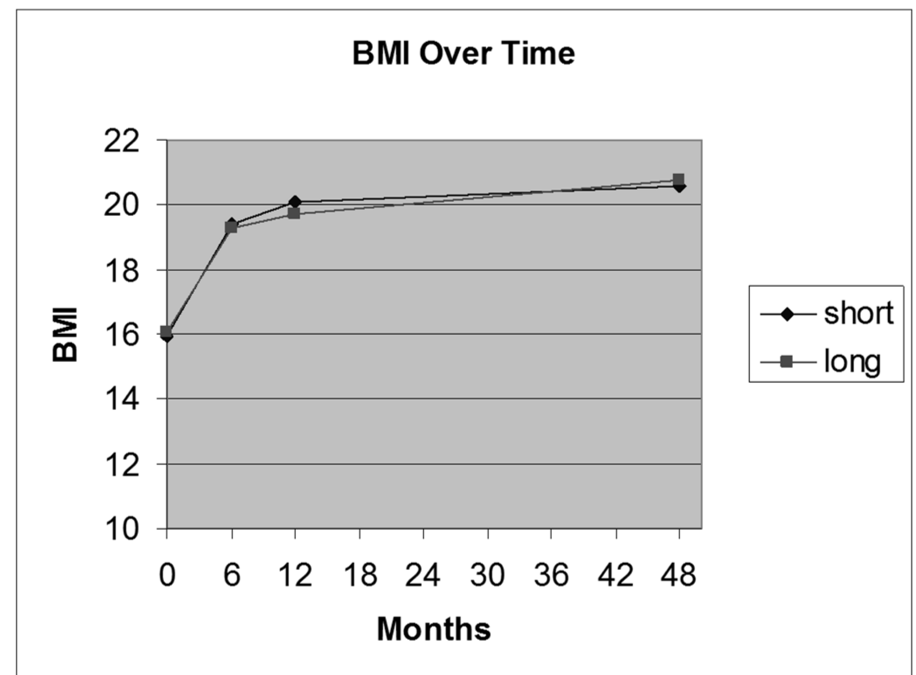


Stanford Dosage Study (N=86)

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

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

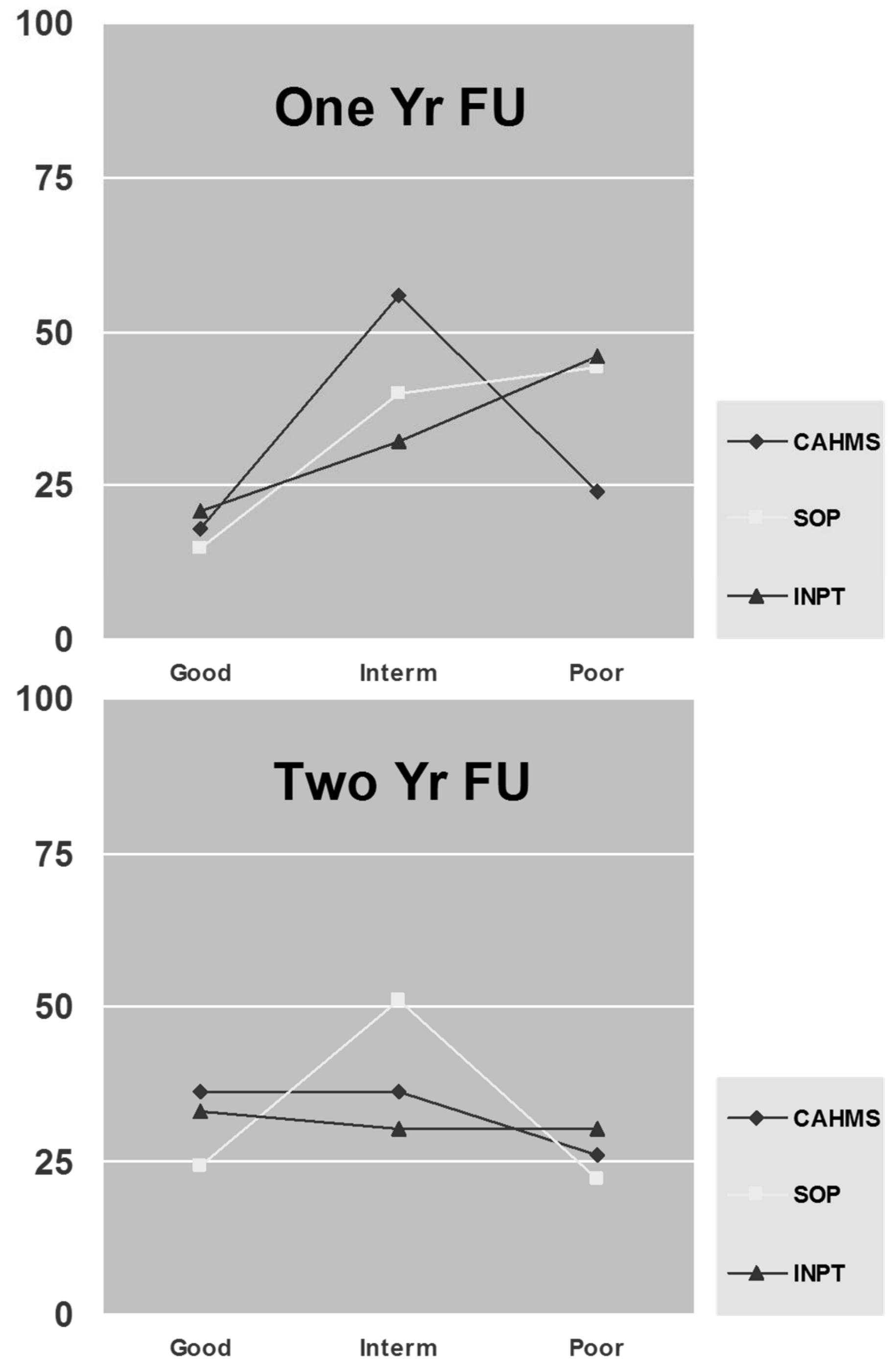




Liverpool RCT (N=167)

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

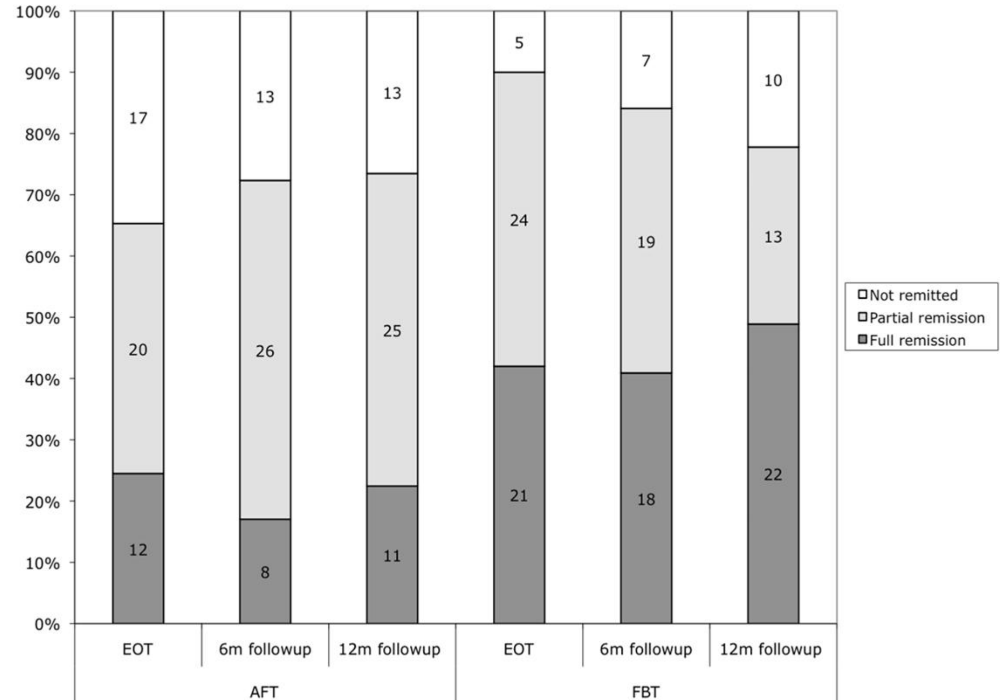
Gowers, Clark, Roberts, Griffiths, Edwards, Bryan, Smethurst, Byford & Barrett, *Br J Psych*, 2007.

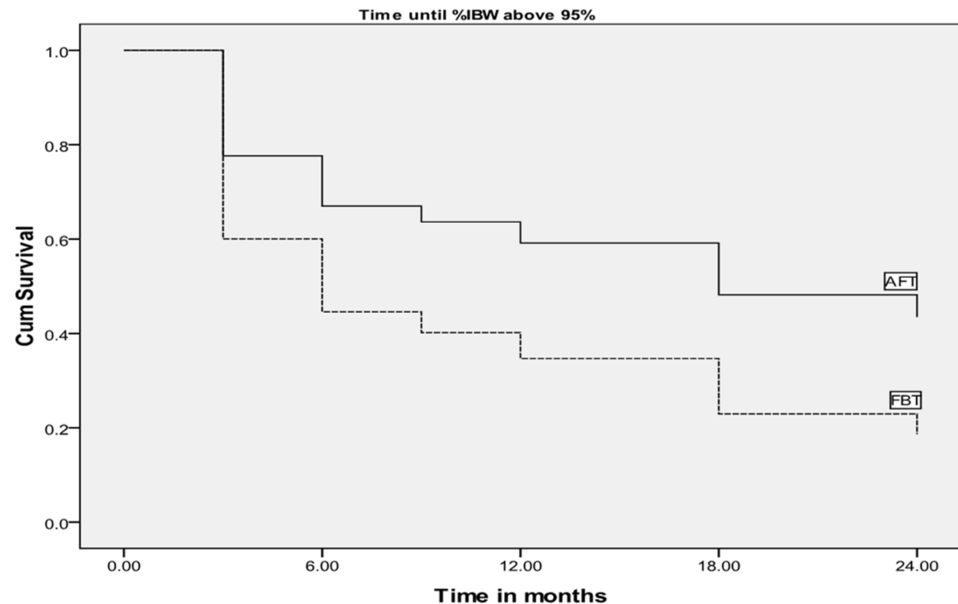


Chicago/Stanford RCT (N=121)

- **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

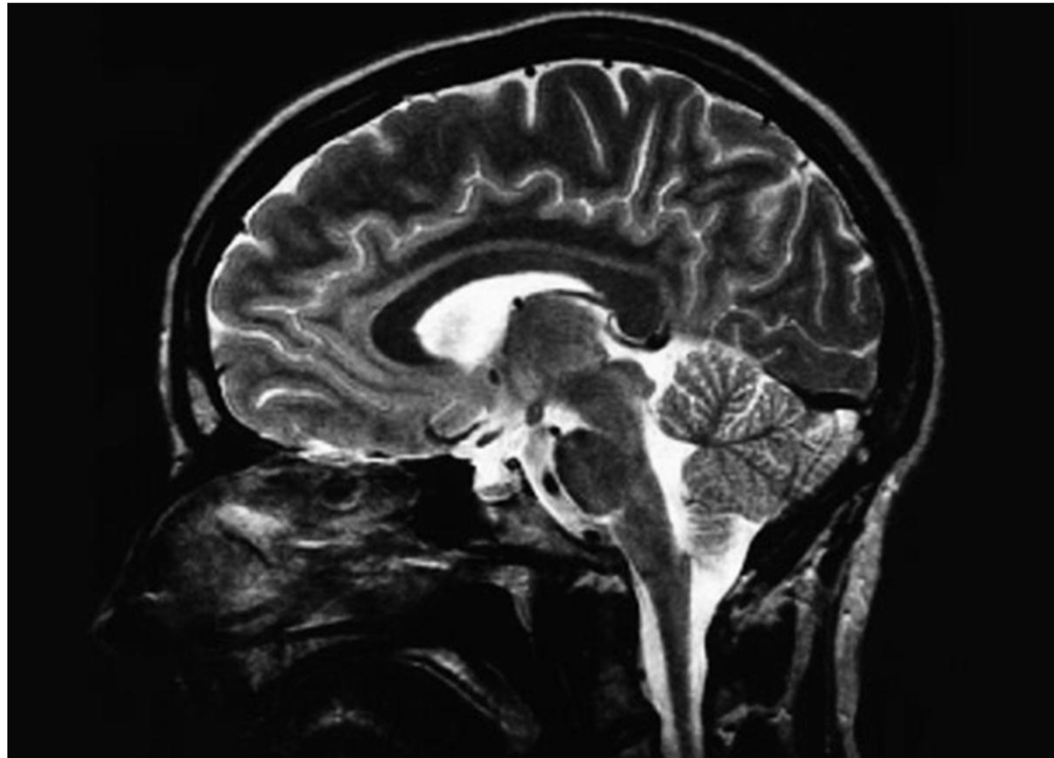
④ Externalization of Illness

- 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

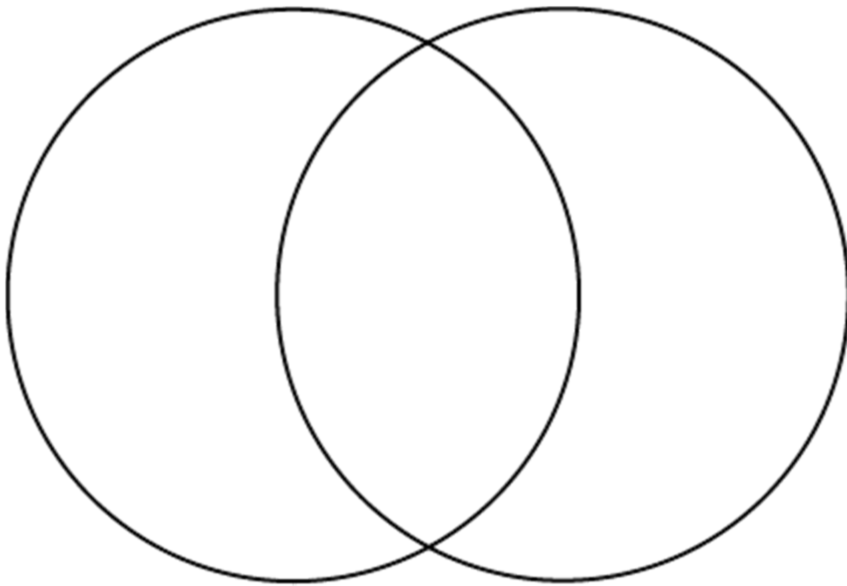
- Disease model (cancer)
- Possession model (spider, alien)
- Intellectual model (Venn diagram)
- Scientific model (genetics)
- Psychological model (behavioral regression)
- Treatment Process (sand hill, Venn diagram, j-curve)

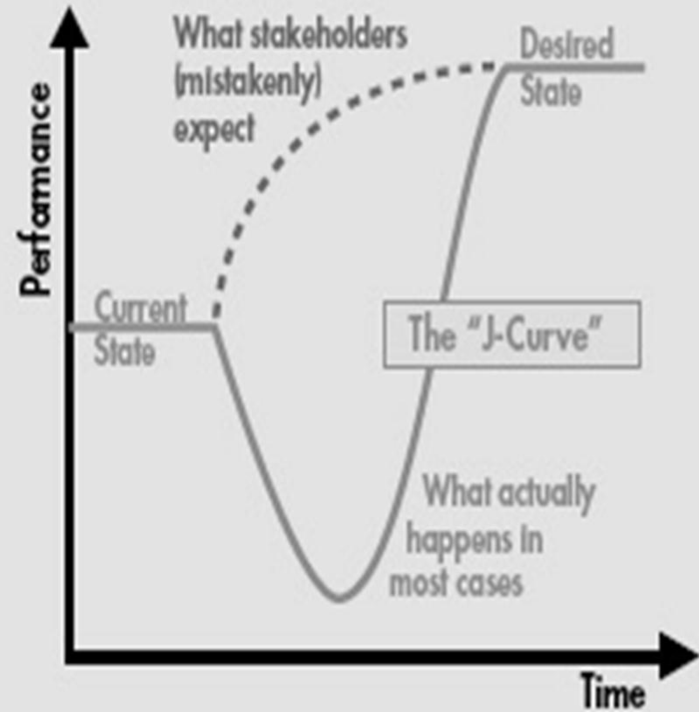
Cancer Model



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

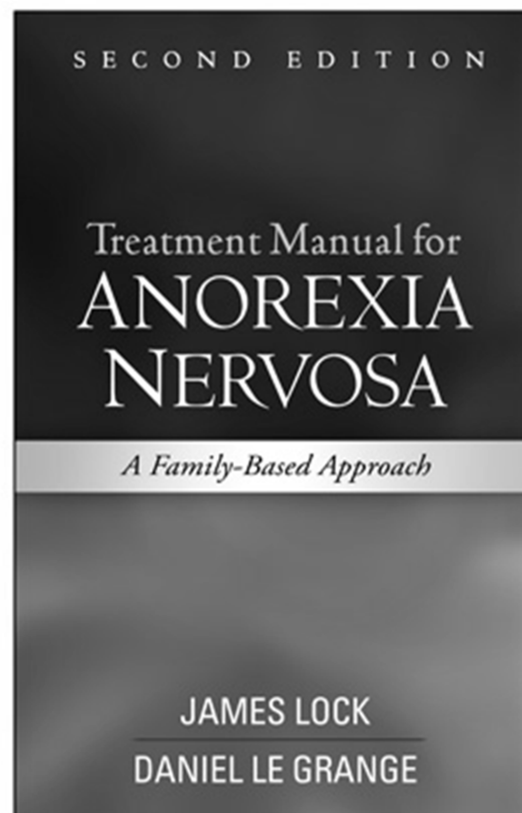
Strategies for Remaining Focused

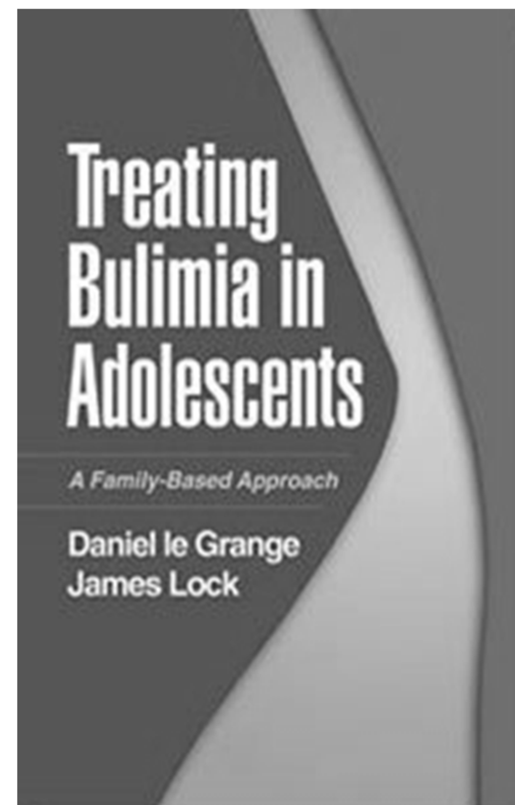
- Use weight chart
- Avoid “other issues” e.g. etiology, causation
- Strategy to limit medical aspect of AN (as maintaining factor - glucose on the brain - and sequelae of starvation)
- Keep tasks of session “in mind”

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

- 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 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

- 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

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.