The Role of Family Therapy for Adolescents With Anorexia Nervosa

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The inclusion of parents in their children's treatment for eating disorder is not universally accepted. However, recent studies suggest that families should be included in treatment and that they are often a powerful resource for helping their children recover.

Anorexia nervosa (AN) is a serious psychiatric condition with a prevalence estimated at 0.48% to 0.7% among adolescent females aged 15 to 19 years. Comorbid psychological conditions are also common in patients with AN. Some 60% of patients with eating disorders have a lifetime anxiety or affective disorder. The mortality rates associated with this severely disabling condition are higher than for any other psychiatric disorder, with about half of the deaths occurring from suicide and the remainder as a result of the physical complications of AN. In addition, AN is an expensive illness to treat, with costs comparable to those for schizophrenia.

Family therapy, one of the few treatments for AN that has been systematically examined, may show the most promise, especially for adolescent patients. The inclusion of parents in their children's treatment for eating disorder is not universally accepted, particularly when parents are encouraged to make strong behavioral interventions. However, recent studies suggest that families should be included in treatment and that they are often a powerful resource for helping their children recover.

"Worst attendants" or partners in recovery?
The role of families in the management of AN has been controversial from the earliest medical descriptions of the disorder. Gull called families the "worst attendants" and Charcot referred to parents as a pernicious influence on their offspring with AN. The clinical recommendation arising from these observations was to remove the parents from involvement in their child's care in a maneuver sometimes called parentectomy. Other experts have justified excluding or minimally involving families when treatment targets the individual developmental needs of adolescents, including autonomy, assertiveness, and self-control.

In contrast, Minuchin and colleagues found that family involvement in treatment appeared to benefit young patients with AN, albeit with a focus primarily on ameliorating family pathology related to rigidity, enmeshment, conflict avoidance, and overprotectiveness. It was left to Dare and Eisler and their colleagues at the Maudsley Hospital in London to develop a family treatment protocol that used families as a therapeutic resource to enhance recovery for adolescent AN.

The birth of FBT
Family-based treatment (FBT), sometimes called the Maudsley method or Maudsley approach, is a treatment that was inspired by Minuchin's findings that families could be an asset in treating youngsters with AN. Dare and Eisler also recognized that inpatient weight restoration in the hands of competent staff often set the stage for recovery. They believed that parents, with appropriate guidance and encouragement, could provide the support at home, thus avoiding hospitalization. As a result, Dare and Eisler developed an outpatient therapeutic approach to help parents disrupt extreme dieting and exercise in their children. Their program aimed to assist parents in normalizing their children's eating and weight in a way similar to what is done in an expert inpatient eating disorder unit. A manual detailing this approach has been published and used in both clinical and research settings. A parent guide has also been written to support parents in learning about this form of family treatment.

Treatment protocols
Early in FBT, parents are helped to understand the medical and psychiatric seriousness of AN, including the high mortality rates because of cardiac failure and suicide. Although this information raises parental anxiety, the therapist uses this information to show parents that they are a crucial resource in preventing devastating outcomes. Parents are encouraged to find solutions to the problems of food refusal and weight loss-inducing behaviors. Usually this entails helping the parents agree on a strategy to increase the amounts and types of food their child is eating and to limit the child's physical activity. Thus, in the first part of the
FBT program, parents learn to get organized, become consistent, and be persistent without getting angry and frustrated with their child. At the beginning of treatment, FBT is highly focused on eliminating food refusal and promoting weight gain. Issues related to family or individual processes are deferred unless they directly interfere with weight restoration. Once weight is restored and the adolescent is eating more regularly, control of eating is returned to the adolescent. After the adolescent demonstrates sufficient ability to eat normally and maintain a normal weight, therapy turns to more general issues of adolescent development and family process.

The major innovation of putting parents in control of weight restoration sets FBT apart from other therapies for AN. Like parents of children with autism, schizophrenia, and other illnesses, parents of children with AN have long felt blamed, responsible, and guilty for their children's illness. As a result, they felt powerless to help their children.

FBT aims to diminish these sentiments and powerlessness in several ways. First, parents are reminded that there is no known cause for AN. The approach further empowers parents by encouraging them to directly challenge and disrupt the severe dieting and overexercise associated with AN as they would any other dangerous adolescent behavior (eg, alcohol or drug use, truancy, or recklessness). The issue of adolescent control is reformulated to help parents see that extreme dieting and the resulting malnutrition are evidence that their child needs help and should not be left to his or her own devices regarding eating behavior. **What the studies show**

There are only 5 randomized controlled outpatient trials of psychological treatment for adolescents with AN (**Table**).9,13-16

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<th><strong>Trials of psychological treatment for adolescents with anorexia nervosa</strong></th>
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**TABLE**
FBT, family-based treatment. These trials were conducted over the past 20 years and comprised about 200 participants. All of these trials involved FBT in some form. Taken together, these studies suggest that family therapy is acceptable, feasible, and effective. In fact, dropout rates were modest (between 10% and 15%), in contrast to treatment studies of adults with AN, where dropout rates of 40% or more effectively made randomized outcomes difficult to analyze and interpret. Outcomes of adolescents in these studies suggest that between 70% and 80% do well in FBT in terms of weight restoration, normalization of eating-related thoughts and behaviors, and psychosocial functioning. In comparison, outcomes in adult studies report 30% to 40% recovery rates.

Studies comparing FBT with other approaches are few and small in scale. Although the results available suggest that FBT may be superior in adolescent participants, definitive conclusions about comparative outcomes await further study. Interestingly, studies of adults with AN who were treated with FBT are less convincing; in such cases, FBT may be no better than individual therapy.

Long-term outcomes of adolescent patients treated with FBT suggest that the improvements obtained during treatment are enduring. Two studies have demonstrated that both weight restoration and eating-related thoughts and behaviors continue to be improved at follow-up 4 to 5 years later. However, although the majority of these adolescents have recovered from their eating disorder and are working or are in school, about a quarter of them have other mental health problems, including depression and anxiety disorders.

Because of the high cost of managing AN, one of the more exciting findings is that FBT can be a remarkably efficient therapy. In its chronic form, AN is highly intractable to known interventions, often requiring long-term and intensive interventions. However, many younger and less chronically ill adolescent patients appear to respond favorably with the relatively short treatment protocols of family therapy.

Based on a review of existing studies of FBT for adolescents with AN, the duration of treatment ranged from 6 months to 18 months, with most treatment durations falling between 6 months and 12 months. Intensity of treatment (number of sessions provided during the treatment period) ranged from 9 sessions to 31 sessions over a 12-month period. In these studies, the weighted (by number of patients in study) mean number of sessions per year was 14.85. Outcome did not appear to vary as a result of the intensity or duration of treatment, since participants who were treated for as few as 9 sessions over 6 months did as well as those who were treated for 47 sessions over 18 months.

In a randomized clinical trial designed to examine the effect of intensity and duration, Lock and colleagues found no differences in any outcome measure between those randomly allocated to receive 10 sessions over 6 months and those receiving 20 sessions over 12 months. However, for patients with severe obsessions and compulsions related to eating behaviors or for those who came from nonintact families, longer treatment appeared to be more effective. Overall, the findings of this study provide substantive support that a brief course of treatment is as effective as a longer course in adolescents who are treated with FBT. These results highlight the advantage of employing parents in FBT not only in terms of promoting recovery but also clinical efficiency and cost-effectiveness.

Two studies have examined patient and family views of FBT. Both studies found that patients and families thought FBT was helpful and successful, but approximately one third of the adolescents in one study reported a desire for individual treatment in addition to FBT. These studies suggest, somewhat surprisingly given the ego-syntonic nature of AN, that adolescents as well as their parents not only accept FBT but also develop strong therapeutic relationships with the therapist. For example, in one study, early patient therapeutic alliance in FBT facilitated early weight gain, and early parental therapeutic alliance helped prevent dropping out of treatment. There is another noteworthy finding: the study found early weight gain was a better predictor of end of treatment psychological recovery and of end of treatment therapeutic alliance than early therapeutic alliance. This underscores the importance of early behavioral response both to the process of therapeutic engagement and to ultimate outcome in FBT for adolescent AN. FBT appears to work best with adolescents who have uncomplicated, short-duration AN. Comorbid
psychiatric illness and family problems appear to increase dropout rates as well as decrease response rates.\textsuperscript{26} Although systematic studies of the mechanisms of the therapeutic action of FBT have yet to be conducted, improvement in comorbid psychiatric symptoms and family pathology early in treatment is associated with increased response rates. In addition, as is common with many treatments for eating disorders, early response, such as weight gain in a patient with AN, also increases the likelihood that the patient will recover.

Two studies have also found that FBT can be delivered in a separated form, wherein the parents are seen separately from their child for therapy focused on weight restoration.\textsuperscript{13,15} This form of FBT may be preferable in cases in which there is a high degree of overt criticism (eg, high levels of expressed emotion) of the child. **Concluding thoughts and future directions**

Since Dare and Eisler's first published studies of FBT more than 20 years ago, a collection of both uncontrolled and controlled studies have been conducted using this approach.\textsuperscript{4} Although none of these studies are definitive, together they produce considerable evidence in support of FBT for adolescent AN. This has been recognized in the National Institute for Clinical Excellence in the United Kingdom evidence-based practice report, in the Agency for Healthcare Research and Quality recommendations and, most recently, in the new practice guidelines for the treatment of eating disorders by the American Psychiatric Association.\textsuperscript{22,27,28} Nonetheless, there is a clear need for more definitive comparative studies. Funded by the National Institutes of Health, a randomized controlled trial comparing FBT to a developmentally tailored individual treatment for adolescents with AN is currently under way at the University of Chicago and Stanford University. Studies comparing FBT to other forms of family therapy for AN in adolescents are being initiated in other centers, including Cornell University, Washington University, Lauriette Psychiatric Clinic and Hospital, Sheppard Pratt Health System, and the University of Toronto. We hope that these larger-scale studies will identify the best treatments, as well as help to determine the best therapy for each individual.

New directions for studying FBT include assessing the utility of the approach for adolescents with bulimia nervosa, evaluating FBT's effects on young adults living at home or with relatives, as well as assessing the integration of the approach in more intensive treatment settings such as day programs, intensive outpatient programs, and inpatient programs. Other therapy formats, particularly family group formats, are also being developed.\textsuperscript{29} A particular challenge common to many evidence-based treatments is efficient and effective dissemination of the approach to clinicians in practice. Training professionals and future professionals in FBT remains a limiting factor in making this approach available to patients outside of specialty centers.

The long-standing controversy concerning whether parents should be involved in the treatment of their adolescent children with AN appears to be resolving. The studies of family treatment conducted thus far clearly support actively including parents in the treatment of their adolescent children with AN. Parents and other family members are an important resource, especially for these younger patients in crisis. Most important, by using family treatment it appears to be possible to forestall the evolution of more chronic, often intractable, and devastating forms of AN.

**References:**


**Evidence-based References**


Dr Lock is associate professor of child psychiatry and pediatrics in the department of psychiatry and behavioral sciences at Stanford University School of Medicine, where he has taught since 1993. He is board-certified in adult as well as child and adolescent psychiatry. He directs the eating disorder program in child psychiatry and is active in treatment research for children and adolescents with eating disorders.

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