CHAPTER 2

Family-Based Treatment for Anorexia Nervosa

Specific Review of Family Therapy Literature

While only a brief review of the range of approaches to family therapy for AN can be presented here, we believe this overview helps place this manualized version of FBT in context. We also hope to show how FBT incorporates elements of some of these other approaches in a new synthesis specifically designed to treat adolescents with AN. Readers interested in a more thorough discussion of these other family therapy approaches are encouraged to consult the references cited in this discussion.

In the traditional model of family therapy, the patient is seen as having developed a problem in response to various external factors (e.g., genetic, physiological, familial, sociocultural). In this model, treatment is conceptualized as aimed at the individual and designed to counteract the effects of these external causative factors. Thus, traditional family therapy views AN as part of a family system and family therapy interventions attempt to modify the problems within the family or, if this fails, to remove the child from the family (Harper, 1983).

Structural family therapy developed an approach to AN from the perspective of treating psychosomatic families (Liebman, Minuchin, & Baker, 1974; Minuchin et al., 1975). This perspective views children in such a family as being physiologically vulnerable in the context of so-called psychosomatic families. According to Minuchin, these characteristics include enmeshment, overprotectiveness, rigidity, and avoidance of conflict. In

addition, the child is seen as having a critical role in the family's avoidance of conflict that acts as a powerful reinforcement for symptoms. Structural interventions are designed to alter the family organization by challenging alliances between parents and children that disrupt parental effectiveness. This is accomplished by encouraging the development of stronger sibling subsystems and by facilitating more open communication both within the family and within the larger social context. While FBT does not view families of patients with AN as "psychosomatic," there is a focus in the approach on the impact of AN on the family structure. Concern about the symptoms of AN can disrupt parental authority and undermine the alignment of parents, making them less effective in helping their child recover. When using this approach within families with eating problems, Minuchin added a therapeutic family meal in which parents are encouraged to take control of the meal. When this is done, the daughter's emotional involvement with her parents is reduced, while at the same time the parents, through their work together, reinforce the effectiveness of their own parental dyad. Some elements of this approach underlie the family meal used in the treatment of adolescent AN in FBT.

Strategic family therapy has also contributed to some of the approaches that are employed in the FBT. In particular, the "agnostic" view regarding the etiology of psychological disorders is an important shared starting point. Haley (1973) and Madanes (1981) express this view as a lack of interest in the causes of illness; thus the scope of their proposed interventions is more circumscribed and aims at limiting the impact of symptoms on the patient and family. There is a stated lack of interest in the cause of AN in FBT. The cause is unknown and focus on the cause takes energy away from the immediate task at hand, which is for the parents to find a way to stop restrictive eating. In addition to agnosticism, FBT includes interventions with paradoxical intentions (e.g., asking a child to resist parental efforts to get her to eat in order to prevent premature compliance with parental authority) or suggesting that the patient undertake behaviors that challenge the symptom (e.g., recommending a patient eat in order to have the strength to fight her parents) that have origins in strategic family therapy. Again, FBT incorporates some paradoxical injunctions in order to support the parental efforts at weight restoration while also acknowledging the adolescent's need to resist these efforts.

Systemic family therapy shares some characteristics with strategic and structural approaches; however, the most significant departure is in the formulation of the family as a rigidly organized homeostatic mechanism resistant to change from the outside (e.g., Selvini Palazzoli, 1974). The therapist

remains neutral in this model to avoid provoking powerful homeostatic mechanisms that maintain the family system that increases resistance to learning in treatment. Thus, instead of making direct interventions, the therapist interviews the family, encouraging the family to become observers and challengers of their own process. End-of-session reviews are used to reframe observed patterns in ways that connote a positive view of family process. Both of these techniques are included in manualized FBT. Specifically, as will be seen, the family is encouraged to find solutions that work for them rather than to rely on the outside authority of the therapist. In addition, the therapist makes a consistent effort to hold the family and its efforts in a positive, noncritical regard throughout FBT.

Feminist theory has added a critical perspective on some of the structural and strategic approaches to family therapy that emphasize the therapist's hierarchical relationship to the patient and family. Feminist therapists emphasize instead the need for partnership and shared control of the therapeutic process (e.g., Madanes, 1981). Although the approach used in this manual insists on the need for parental control of the child's eating with AN during the critical early phases, it also explicitly calls for developing a partnership with the healthy part of the adolescent's growth process, even if it may sometimes defy parental wishes. The therapist aims to form a sincere partnership with both the parents in their tasks, as well as with the adolescent in hers.

Each of these schools of thought on family therapy makes contributions to the particular type and style of interventions used. Detail is provided in the "Why" sections in each chapter that illustrate the more specific theoretical connection between the intervention and other forms of family therapy.

Eisler (2005) has proposed one way to conceptualize what happens to families as they try to address the problematic behaviors of their child with AN: They are the result of accommodations made to the emerging symptoms of the disease that change how the family normally functions. Similar to the types of accommodations that families make for a child with a physical illness, as described by Steinglass (1998), families adjust to the developing symptoms of AN by withdrawing, narrowing their focus, and losing the ability to plan for the future; furthermore, their resources for taking care of the needs of other family members diminish. The crisis of AN is likened to the crisis of a serious medical illness. Thus the family is seen as trying to accommodate to the crisis of AN, and only when the crisis is abated can it possibly resume the productive processes of a developing family.

Family-Based Treatment and the Evolution of This Manual

The research literature listed in Table 2.1 documents the current evidence base for the treatment of adolescent eating disorders. It provides a specific review of studies supporting manualized FBT for adolescent AN. Prior to manualization of FBT, the seminal preliminary conceptual studies were conducted by Dare, Eisler, and colleagues at the Institute of Psychiatry at the Maudsley Hospital in London (Lock, 2016; Russell et al., 1987). The initial randomized controlled trial conducted by this group compared family therapy with supportive individual therapy in a sample of adults and adolescents with AN and adults with bulimia nervosa (BN) in an outpatient setting. Prior to randomization, all underweight patients were treated in the hospital to a weight of 90% of expected weight for height. Overall, the study found that, compared with older patients and adolescents with a longer duration of AN (>3 years), adolescents with a short duration of AN showed greater improvement using a form of family therapy similar to the one described in this manual. However, it must be pointed out that out of a total sample of 20 adolescents with short duration AN, only 10 received family treatment and it was only this group that showed differential benefit of this approach. Adolescents who had been ill for more than 3 years and adults with AN or BN showed no differential treatment effects. A 5-year follow-up of the original cohort confirmed the maintenance of the positive outcome for the young patients with AN who received family therapy (Eisler et al., 1997).

Two additional studies have compared forms of family therapy similar to FBT (behavioral family systems therapy [BFST]) to individual therapy aimed at helping adolescents with self-management of their symptoms and focusing on adolescent issues. The first of these was conducted by Robin and colleagues (1994, 1999) and compared BFST, which promotes parental control of weight restoration in a similar way to FBT, but also includes a CBT component, with ego-oriented individual therapy (EOIT). EOIT is an active, developmentally focused individual therapy aimed at promoting self-efficacy and developmentally appropriate autonomy while involving parents in supporting this through collateral sessions (Robin, 2003; Robin et al., 1999). Consultation with a dietician to support EOIT was also a part of this study. Both treatments lasted about 16 months, and overall the majority of the 37 female adolescents randomized did well. However, those who received BFST gained more weight and experienced greater rates of menstrual return than those in EOIT, both at the end of treatment

TABLE 2.1. Treatment Trials of Manualized FBT for Adolescent AN

Study	Treatment type[a]	*N*	Outcomes
Lock et al. (2005)	FBT for 10 sessions/6 months or FBT for 20 sessions/12 months	86	No difference between groups. Moderators: Nonintact families and adolescents with high OCD feature related to eating did better with 20 sessions/12 months.
Lock et al. (2010)	FBT vs. AFT	121	Recovery rates were approximately twice as high in FBT (40–50%) compared to AFT (20–25%).
Agras et al. (2014)	FBT vs. SFT	164	No difference in rates of remission or recovery between the treatments by the end of treatment. Rates of weight gain were faster in FBT, hospitalization was lower, and costs were lower in FBT.
Le Grange et al. (2016)	PFT vs. FBT	107	There were no differences between the two treatments, but PFT appeared to work faster and better for adolescents whose parents were higher in expressed emotion.
Lock et al. (2018)	FBT + CRT vs. FBT + art therapy	30	There were few overall differences between the two treatments. Improvements were found in cognitive processes in both treatments.
Lock et al. (2021)	GSH + FBT vs. FBT	40	No differences in clinical outcome between the two approaches, but GSH + FBT was more efficient using one-fourth of therapist time compared to FBT.
Lock et al. (2024)	FBT + IPC vs. FBT	69	No difference between the two treatments. Families with baseline low levels of PSE combined with poor early response did better with IPC added to FBT.

[a]FBT, family-based treatment; AFT, adolescent-focused therapy; SFT, systemic family therapy; PFT, parent-focused therapy; CRT, cognitive remediation therapy; FBT, family-based therapy; GSH, guided self-help; IPC, intensive parental coaching; PSE, parental self-efficacy.

and at 1-year follow-up. There were no differences in outcomes on any psychological or family variables. Due to the small sample size, this study provided only preliminary support for the possible superiority of family therapy over individual therapy.

To address this shortcoming, another study using a multisite design compared manualized FBT with manualized adolescent-focused therapy (AFT) in 121 adolescents who met all criteria for AN except the amenorrhea criterion (Lock et al., 2010). AFT is a therapy similar in design to EOIT, but it did not include consultation with a dietician in this study (Fitzpatrick, Moye, Hoste, Lock, & Le Grange, 2010; Lock, 2020). Treatment lasted 1 year and consisted of 24 hours of therapy contact hours in both FBT and AFT. FBT was superior to AFT in terms of change in weight (percentile body mass index [BMI]) and eating-related psychopathology (Eating Disorder Examination [EDE] global score) at the end of treatment. Recovery rates (defined as weight greater than 95% mean body weight and EDE score within one standard deviation of community norms) did not reach statistical differences at the end of treatment (FBT = 42%; AFT = 19%), but favored FBT at follow-up (FBT = 50% vs. AFT = 20%). Weight gain was faster, hospitalization rates were lower, and maintenance of recovery rates was greater in FBT. Thus, in combination with the results of the preliminary studies, it is reasonable to conclude that for most adolescents with AN, family therapy is a better option that AFT.

As noted above, there are a number of different types of family therapy that have been utilized in AN, but it was not clear if one family approach was better than others. Only one study has been conducted that compared systemic family therapy (SFT) to FBT. This was a 7-site study with 164 adolescent participants and their families (Agras et al., 2014). It required a larger number of participants because there was some overlap in the two approaches. Both—as noted above—utilize some systemic family interventions, making it more likely that they would have similar treatment effects. Indeed, the overall clinical outcomes (weight gain, cognitive changes, recovery, and remission rates) were statistically identical. Importantly, however, there was a significant difference in rate of weight gain, with FBT being quicker, and use of hospitalization, with FBT needing far fewer admission days. These findings suggest that FBT works faster and is less costly than SFT.

There have been additional studies that have explored how best to deliver FBT. Several studies examined different ways family therapy for AN could be administered. The first study was a small pilot randomized controlled trial that included 18 adolescent females and provided

only outpatient family-based treatment (no inpatient weight restoration prior to randomization) for 6 months and about 10 sessions (Le Grange et al., 1992b). Patients were randomized to either whole-family treatment or parental counseling combined with supportive individual therapy (separated-family treatment). There were no differences in outcome between these two forms of therapy, though there was a suggestion that families with higher levels of criticism (expressed emotion) fared better in separated-family therapy. A larger study that included 40 adolescent females randomized to these two forms of FBT confirmed these findings (Eisler et al., 2000). Finally, this separated approach was renamed parent-focused therapy (PFT) and compared to manualized FBT. In PFT only the parents are seen while the adolescent is medically monitored (Le Grange et al., 2016). The interventions the parents receive are identical to those they would receive if the child and siblings were present. The results suggested that PFT may work more quickly and be more effective for families with higher levels of criticism. In this manual, we will describe in more detail how PFT modifications can be used in FBT so that therapists can use the approach that is most appropriate for a particular family.

Studies have been conducted exploring whether a guided self-help (GSH) version of FBT using online training materials would be effective, since it could potentially allow for greater dissemination of FBT at lower costs. Initial studies suggested that GSH-FBT was acceptable and outcomes appeared consistent with those found in other studies. A randomized feasibility study confirmed these findings and supported a larger randomized controlled trial comparing GSH-FBT to FBT (Lock, Darcy, Fitzpatrick, Vierhile, & Sadeh-Sharvit, 2017). This format of FBT has the potential to greatly expand access to care and facilitate dissemination of the approach and discussed in more detail later in this volume.

Another study examined the efficiency of FBT by comparing a 6-month, 10-session version with a 12-month, 20-session version of the approach (Lock et al., 2005). In this study, 86 adolescents with AN using DSM-IV criteria excluding the amenorrhea criterion were randomized to these alternatives. There were no differences between the two groups at the end of treatment or at 1-year follow-up in terms of weight gain or changes in eating-related psychopathology. Overall, the patients did well, with approximately 60% reaching full recovery (weight >95% of expected and normal EDE) and over 90% no longer meeting the DSM-IV suggested weight criterion (85% of expected weight for height) for AN. This was also the first study to employ the manualized form of FBT described in this book.

In addition to these efficacy studies, moderators of treatment response to FBT for adolescent AN have been explored. Moderators are baseline characteristics of patients or families that may determine differential effectiveness of a particular treatment for a particular patient. In the study comparing different amounts of FBT, two moderators of outcome were identified (Lock, Couturier, & Agras, 2006; Lock, Couturier, Bryson, & Agras, 2006). Patients with high levels of obsessive–compulsive features related to eating and those from nonintact families (divorced or single-parent families) did better when they received the 12-month, 10-session treatment. Thus, therapists who identify patients with high levels of obsessive–compulsive features related to AN, or who are treating families that are not intact, should plan on a 20-session treatment over a year to increase the likelihood of a good outcome.

A common maxim of treatment is that those who respond early are likely to have the best outcome. This also appears to be true for manualized FBT. Several studies have identified early weight gain in the first several sessions as a powerful predictor of end of treatment outcome. For example, in several studies weight gain of approximately 2.4 kg (about 5 pounds) by Session 4 of FBT predicted with 80% accuracy who would reach normal weight by the end of treatment (Doyle, Le Grange, Loeb, Celio Doyle, & Crosby, 2010; Agras et al., 2014). As a result of this finding, adaptions of FBT have been developed to help families whose child fails to make this weight gain (about 40–60%). Intensive parental coaching (IPC) is a three-session intervention (described in more detail in later chapters). To assess if adding IPC to standard FBT improved outcomes, a randomized controlled trial comparing FBT + IPC to FBT in those who did not respond early (i.e., did not gain 2.4 kg (about 5 pounds) by Session 4) was conducted. Results suggested that for most families, IPC did not improve outcomes; however, for parents who had low levels of parental self-efficacy before starting treatment *and* whose child did not respond early, adding IPC greatly improved their child's chances of recovery. About 25% of families would likely be in this group and therefore rates of recovery when this baseline moderator of outcome is considered should increase proportionately (Lock, Le Grange, Bohon, Matheson, & Jo, 2024).

There has been increased interest in the cognitive profile of adolescents with AN. Data suggest that adults with AN have thinking styles that are inflexible (or perseverative) and overly detailed focused (neglecting the big picture). These thinking styles are best considered inefficient rather than deficits but are shared by other disorders such as OCD and ASD. However, most studies suggest these styles of thinking are associated

with the starvation state and mostly remediate with weight gain. This is particularly true for adolescents who have had a short duration of AN. Nonetheless, studies have been conducted to see if helping adolescents who are acutely ill with perseverative and overly detailed thinking styles might improve their outcomes. Preliminary data using CRT adjunctively to FBT found some benefits, but these did not lead to large clinical improvements and further studies are needed to see if adding CRT to FBT is clinically useful (Pretorius et al., 2012; Lock et al., 2018). Nonetheless, this book includes additional material on how FBT might be utilized to intervene with adolescents with these types of cognitive inefficiencies.

It is also noteworthy that, since the publication of the initial version of this treatment manual, FBT has been used with adolescents with BN. A randomized controlled trial that randomized 80 adolescent women with BN and subthreshold DSM-IV BN compared FBT (manualized) with a supportive psychological treatment (Le Grange, Crosby, Rathouz, & Leventhal, 2007). FBT was superior at the end of treatment and at 1-year follow-up. Overall rates of recovery (defined as abstinence from binge eating and purging for 4 weeks prior, according to the EDE) were superior in FBT. More recently, a larger randomized controlled trial compared manualized FBT for BN to CBT for BN in an adolescent sample of 136 participants (Le Grange, Lock, Agras, Bryson, & Jo, 2015). Results of that study found that at the end of treatment FBT-BN was superior to CBT in rates of remission from binge eating and purging behaviors. At follow up, though FBT continued to have higher rates of remission, the difference was no longer statistically significant. Most clinical guidelines for adolescent BN now recommend FBT as the first line treatment for this condition (National Institute for Health and Care Excellence [NICE] guidelines).

Taken together, data from these studies provide a firm foundation of empirical support for the use of FBT for eating disorders in adolescents.

Why Use a Manual?

We hope it is evident from the studies described above that FBT is effective for the treatment of adolescents with AN. Using a manual-based therapy benefits both the therapist and the patient. First, the structure, although flexible, ensures that the treatment procedures are sequenced in an optimal fashion and that all the components of therapy are adequately covered. Second, a manual keeps both the therapist and the family on track. Without the benefit of a manual, a considerable amount of therapy time may easily be devoted to issues that are not central to the treatment of AN in

adolescents. In this sense, this manual illustrates a highly focused treatment aimed initially at weight restoration and return to physical health, and progressing to address age-appropriate independent eating and adolescent issues. Third, the procedures described in this manual have been tested in controlled outcome studies; thus both the client and the therapist can have confidence that the treatment works.

Introduction to Family-Based Treatment

The theoretical understanding or overall philosophy of FBT is that the adolescent is embedded in the family and that the parents' involvement in therapy is vitally important for ultimate success in treatment. In FBT the adolescent is seen as being unable to make good decisions about eating and related behaviors because of distortions associated with a diagnosis of AN. Therefore, parents should be involved in their child's treatment while showing respect and regard for the adolescent's point of view and experience. This treatment pays close attention to adolescent development and aims to guide the parents to eventually assist their adolescent to re-enter and effectively engage with these developmental tasks once the crisis of AN is mitigated. In doing so, the therapist should ask the family to defer addressing most other family conflicts or disagreements until the eating-disordered behaviors are resolved. Normal adolescent development is seen as having been arrested by the development of AN and for this reason, parents are temporarily put in charge to help reduce the hold this disorder has over the adolescent's life. Once successful in this task, the parents will return control of eating and related issues (e.g., exercise) to the adolescent and assist her in the usual negotiation of predictable adolescent developmental tasks.

FBT differs from other treatments for adolescents in several key ways. First, as pointed out previously, the adolescent with AN is not viewed as being in control of her behavior; instead, the eating disorder controls the adolescent. Thus, because of her illness, and in this way only, the adolescent is seen as not functioning on an adolescent level but instead as a much younger child who needs a great deal of help from her parents. Second, the treatment aims to reverse the impact AN is having on adolescent health and development by helping parents to take control over the adolescent's eating. Sometimes parents are concerned about taking control because they feel that they are to blame for the eating disorder or because the symptoms frighten them to the extent that they are too afraid to act

decisively. Third, FBT strongly advocates that the therapist should primarily focus initial attention on the task of weight restoration, particularly in the early parts of treatment. FBT tends to "stay with the eating disorder" for a longer time—that is, the therapist remains careful not to become distracted from the central therapeutic task. That task is to keep the parents focused on weight restoration and restrictive eating practices until normalization of both is achieved before proceeding to other issues in the family.

FBT for adolescent AN usually proceeds through three clearly defined phases. Phase I usually lasts between 3 and 5 months, with sessions typically scheduled at weekly intervals. The spacing of sessions should be based on the patient's clinical progress. During Phase II, the therapist may schedule sessions every second to third week, whereas monthly sessions are advisable toward conclusion of treatment (Phase III). All family sessions last about 50 minutes. Before every family session, an initial meeting of approximately 10 minutes is held between the therapist and the adolescent alone. During this meeting, the adolescent is weighed and discusses her experience the week prior. This allows the therapist an opportunity to gauge the adolescent's response to seeing her weight and help her manage any anxiety about weight gain.

In this manual, we first describe the broad goals of each phase, followed by the specific steps that should be followed to achieve these goals. As noted above, studies support that, for many families, FBT can be much shorter—as few as 10 sessions over 6 months, except for patients with more obsessive–compulsive features and those in nonintact families, for whom longer treatment may be beneficial (Lock et al., 2005, 2006).

Phase I: Weight Restoration

In Phase I, the therapy is almost entirely focused on the eating disorder and includes a family meal. The family meal gives the therapist an opportunity for direct observation of the family's interaction patterns while eating. With younger patients the therapist makes careful and persistent requests for united parental action directed toward eating, which is the primary concern at this point of the treatment. This approach permits the therapist to disclaim the notion that the parents have caused the eating problem and instead to express sympathy for the parents' plight. In addition, the therapist directs the discussion in such a way as to create and reinforce a strong alliance between parents in their efforts to promote weight restoration and stop restrictive eating on the one hand and to align the patient with the

sibling subsystem on the other. This phase is particularly characterized by attempting to absolve the parents from the responsibility of causing the illness and by complimenting them as much as possible on the positive aspects of their parenting of their children. The attitude of the therapist should reflect something like the following sentiment:

> "You have been successful with bringing up your children to this point and in your personal and professional lives. We hope to encourage the application of the skills acquired in these earlier successes in helping you resolve the current eating problem with your daughter."

The families are encouraged to work out for themselves how best to help their child gain weight and eat normally, while the therapist provides consistent support for these efforts at all times.

Phase II: Transitioning Control of Eating Back to the Adolescent

The patient's surrender to the demands of her parents to increase her food intake (when steady weight gain or healthy weight stabilization is evident), as well as a change in the mood of the family (i.e., relief after having taken charge of the eating disorder), signal the start of Phase II of treatment. Usually, by Phase II the young person is approximately 90% of expected weight for height, but it is equally important that the young person is consistently eating and gaining weight under parental supervision. The therapist advises the parents to accept that the main task is the return of their child to physical health, but at this phase it is appropriate to allow the adolescent to gradually take responsibility for eating and weight gain while remaining under parental supervision. Although eating-related symptoms remain central in the discussions, weight gain with minimum tension is encouraged. In addition, other issues that the family has had to postpone related to eating can now be brought forward for review. This review, however, occurs only in relationship to the effect these issues have on the parents in their task of ensuring steady weight gain and helping the adolescent take increasing responsibility for her eating and health.

Phase III: Adolescent Issues and Termination

Phase III is initiated when the patient achieves a stable weight nearing normal levels for the particular patient, the self-starvation has abated, and exercise is at a medically safe intensity. Further, the adolescent is able to

demonstrate the ability to eat independently for the most part, both with the family and in other typical settings for her age (e.g., school, friend's home, on school trips, on vacations). The central theme in this phase is the reestablishment of a healthy adolescent or young adult relationship with the parents and reengagement with the developmental tasks of adolescence that AN disrupted. This entails, among other things, working toward increased personal autonomy for the adolescent and establishing more appropriate family boundaries, as well as the need for the parents to reorganize their life together as a couple after their children's prospective departure.

Appropriate Candidates for This Therapy

The patients for whom this type of therapy is most appropriate are adolescents younger than 18 years of age with AN. For the most part, these will be adolescents who are living at home with their families. This is true in part because the therapy assumes that the family eats together and has routine access to one another by living in the same household. Because the therapy asks that parental figures assume leadership in weight restoration for their starving child, it is necessary that meals be routinely eaten together. However, recent studies suggest that young persons between 18 and 25—transition-age youth—may also benefit (Dimitropoulos et al., 2018). Future studies will shed further light on when to use FBT for these older adolescents and young adults.

What constitutes a family is quite variable. For practical purposes, we define the family as those persons who live in the same household as the identified patient. This may mean that a family session should include nonbiologically related household members or grandparents if they live in the home, whereas it may exclude parental figures who are not involved in the day-to-day care of the child with AN. For the most part, we allow the family to define its membership.

FBT as described in this manual involves the entire family. This requires a substantial commitment on the part of parents and siblings to attend therapy sessions. It may require that siblings miss school or other activities to ensure their attendance. The therapy also requires great dedication on the part of parental figures to do what is necessary to help their starving child. This may include taking time away from work, setting aside other pressing issues, and foregoing expected activities for a period. Families for whom this therapy is appropriate must be prepared to make

these sacrifices. As noted above, other formats—including PFT versions of FBT—are effective and may be appropriate for some families.

Possible Modifications

The general perspective of this manual applies to intact families. However, this treatment manual can be modified for nonintact families depending on their status, such as reconstituted or single-parent families, or on the specifics of custodial arrangements. For instance, single parents may have to take on the task of helping their child with weight restoration on their own, or they may wish to seek the assistance of a friend or other relative. Some of these possibilities are discussed in more detail later on.

NONADHERENT FAMILIES

Patients and families are not perfectly adherent with recommended treatments. This is true for all medical problems but may be especially so in families with a child who has AN. Many factors lead families to believe that there is no problem or that they cannot do anything about the problem even if they acknowledge it. Therefore, we do not expect perfect adherence with the treatments in this manual. However, the degree of nonadherence is likely important. It is, after all, not possible to conduct FBT unless the family is present. If the family does not on the whole make scheduled appointments, there is reason to strongly consider that this approach is not likely to be helpful. Families need to be handled supportively in any event, and the possible loss of an important resource for the patient (in this case the family) should be carefully evaluated. Do not give up too soon, as the family is usually the best resource that a patient has for recovery. For the most part, *the therapist is responsible for maintaining the frame of the treatment*—that is, they should hold sessions only when the family members are all present unless a reasonable exception has been agreed to by the therapist and family.

WEIGHT-RECOVERED PATIENTS OR THOSE WITH ATYPICAL ANOREXIA NERVOSA

The therapy was originally designed for patients who need help with weight restoration. If this is not a problem, even though the patient may still have severely distorted thinking associated with AN, it would be

difficult to apply the strategies of the weight restoration discussed in Phase I of the manual. Nonetheless, it is also true that patients who have atypical AN (i.e., have not lost weight enough to be considered significantly underweight) or who have recovered weight in other settings (e.g., hospitals, day programs, residential programs) may still require parental management of their eating patterns in order to keep from losing weight. Biologically female patients who are partially weight recovered may still not be menstruating and therefore still require additional weight gain or persistent weight maintenance or both in order to continue to recover. These patients as a whole are appropriate candidates for treatment using this manual, but the focus may sometimes move more quickly into Phase II and III interventions. This situation requires that the therapist conduct at least the first two sessions of Phase I, but these may soon be followed by sessions that address the need to continue with weight gain or to eat normally and the need for parents to supervise returning responsibility for eating back to the adolescent. We will discuss special adaptations in FBT for these types of patients in more detail in subsequent chapters.

PATIENTS TOO ILL TO BE TREATED OUTSIDE A HOSPITAL

If the therapist experiences difficulty in getting the parents to help their starving child to eat and restore weight, the patient may become too ill to be treated outside the hospital. The therapist must use her best judgment here to determine at what juncture she recommends that the patient be hospitalized. This, of course, is an unfortunate turn of events and may complicate treatment on several levels. First, obtaining a bed in a special eating disorders inpatient unit may prove quite a challenge. Second, the parents may experience a move to an inpatient facility as a further failure on their part, and the patient may become more entrenched in her eating disorder. Third, once the patient is discharged from the hospital, reengaging the family in an effort to mobilize them to make another attempt at this difficult task may prove unsuccessful. Clearly, the therapist should work hard to prevent this scenario from unfolding. However, from time to time it may happen that the therapist has to make arrangements for inpatient treatment.

After a patient is hospitalized, it is still possible to continue FBT. For example, the occasion of the hospitalization may be additional evidence that the eating problem is severe and that it requires the parents to devote themselves to the effort of overcoming the disorder. Hospitalization can

serve as a new crisis to encourage aggressive action. On the other hand, a hospital admission may be experienced as a failure on the part of the family and the therapist. Such a perspective is not helpful and should be contested. Instead, focus should be maintained on the need for the parents to pick up the weight restoration process after their child is discharged.

Because the family is unlikely to be able to participate in the actual weight restoration process of a hospitalized child, the emphasis on any family work should be on the seriousness of the medical problems their child is experiencing and the need for action on the parents' part to turn this around. Continuing to support the parents in developing feelings of empowerment may be difficult in a hospital setting (see the next section), but such support should be undertaken. It is likely that family therapy in the hospital, therefore, must be more limited in scope.

FAMILY-BASED TREATMENT IN INTENSIVE TREATMENT SETTINGS

The question sometimes arises about the application of this type of therapy to an inpatient, day program, or hospital setting. FBT is difficult to apply to most intensive-treatment settings in which professionals remain largely empowered to make clinical decisions. This is not necessarily the result of not wishing to include parents but simply reflects the reality that in such settings parents are not present at all the meals and do not make decisions about what is to be eaten and when. However, the crisis of a hospitalization or admission to other types of intensive-treatment settings can be used at times by therapists to increase the productive concern of parents. This concern, when positively channeled using techniques described in Session 1, can better prepare the parents to take action and responsibility when their child is once again returned to their care. Thus it may sometimes be appropriate for a therapist to conduct Session 1 in an inpatient setting or to repeat the strategies employed in Session 1 with a family if a patient is rehospitalized, in order to get the family rapidly engaged in the treatment process. Further, it is possible to begin the process of increasing parental empowerment in a variety of ways in intensive-treatment settings by involving the parents in programs, educating them about their ability to help their children, and, whenever possible, disabusing them of the belief that they caused AN. Practical involvement in mealtimes when possible is also helpful, as are programs that provide opportunities for parents to take real responsibility for their child's eating at home during evenings and weekends.

Who Is Qualified to Use This Manual?

This manual is intended for use by qualified mental health therapists who have experience in the assessment and treatment of eating disorders in adolescents. Therapists in training under the guidance of experienced clinicians may also use it. It is not intended as a self-help manual. The treatment described should be conducted with appropriate consultation and involvement of professionals in pediatric medicine, nutrition, and child psychiatry.

The Treatment Team

The degree of collegial (e.g., treatment team) and technical (e.g., video recording of sessions) support that the therapist requires will depend on his or her experience with adolescents, families, and eating-disordered patients in particular. This support, of course, will also depend on the setting in which the clinician operates. Few therapists, however, should aim to work completely without any support structures, as it is a complex therapeutic task and the medical vulnerability of patients is high during periods of severe malnutrition. We recommend that the therapy team members include the primary clinician or team leader (e.g., a child and adolescent psychiatrist, psychologist, or social worker) and a cotherapist, whereas a consulting team could consist of a pediatrician, nurse, and nutritionist.

If possible, members of the treatment team should all be concentrated within the same facility. "Partitioning" the treatment out to various clinicians not in direct contact with the primary clinician may lead to difficulties. For instance, the patient may discuss a specific aspect of treatment, such as rate of weight gain, with her pediatrician, who may not be intimately familiar with the primary clinician's treatment philosophy and may inadvertently provide the patient with conflicting information that may have a negative impact on the treatment process by confusing the patient or parents. However, the degree to which a treatment team can be assembled in the same locale without having to partition certain examinations or measurements out to others will, of course, depend on the nature of the setting in which the primary clinician operates.

The FBT therapist is not always someone who can do a physical examination or who has expert nutritional knowledge. Therefore, others who are not directly involved in conducting FBT may be consultants to

the therapist. The FBT therapist should orchestrate a clinical support system that permits immediate access to the information gathered by these other clinicians. In other words, all team members have to be "on the same page." One way in which this can be achieved is for the FBT therapist to establish a simple checklist such as the following, which should be completed at the end of each session and then distributed to all other team members:

- What was the patient's last weight?
- What new problems were noted?
- What are your recommendations?

The Role of the Consulting Team

These are persons not ordinarily acting in the role of the FBT therapist, such as the pediatrician or nutritionist. These members are secondary in the sense that they provide clinical data to patient, parent, and therapist. The FBT therapist should coordinate regular contact with these other clinicians. These team contacts may be in the form of confidential weekly face-to-face team meetings, weekly teleconferencing, or weekly electronic mail or faxing. It is of the utmost importance that the FBT therapist is clearly the leader of this clinical group. Further, the FBT therapist should help to ensure that the other clinical team members are supportive of the FBT model of parental empowerment and intervention. It is important that the other clinicians support the parents in taking responsibility for disrupting starvation and related behaviors and that they convey relevant clinical information to the parents that will allow them to understand how their child is progressing clinically.

Before the therapist's first meeting with the family, arrangements would already have been made for a physical examination of the patient. This information, along with a weight chart, will be available to the therapist prior to meeting with the family. The therapist will weigh the patient during subsequent meetings and often measure height if growth is predicted. Facilities to monitor weight, height, blood chemistry, and cardiac and endocrine status should be available, or arrangements should be set up for a routine medical examination and relevant laboratory tests. This can be accomplished in a variety of ways, mainly depending on the patient's medical status; for example, regular orthostatic checks are advisable, as well as electrolyte screening if frequent purging is suspected.

What to Do If the Therapist Does Not Have Broad-Based Team Support Available

■ *Work in therapy pairs.* It would be beneficial for a therapist to ask a colleague to work along with him or her in providing FBT. Establishing a therapy pair can be advantageous in terms of mutual therapeutic insight and support. Furthermore, family dynamics can have a seductive quality and can lead to the therapist colluding with either the parents or the illness, thereby rendering treatment less effective. In these arrangements, it is best that one of the clinicians be the "active" therapist and the other "observing" so that the family is clear about who the consulting therapist is and to reduce the "airtime" of therapists allowing for more family member contributions.

■ *Establish a relationship with another clinician (e.g., a pediatrician).* To prevent any miscommunication between the lead therapist and another clinician about the treatment procedures, it is best to establish a treatment relationship with pediatricians or adolescent medicine physicians who can become familiar with this treatment approach and to whom all patients can be referred for medical monitoring. Regular meetings are recommended, especially if the FBT therapist shares several patients with other clinicians. For clinicians in the United States, this arrangement may be complicated by insurer patient–therapist purchasing agreements, which ordinarily do not allow for consolidation.

■ *Arrange weekly consultation or supervision with a colleague.* If it is not possible for a colleague to join the therapist in treatment, a weekly supervision or consultation should be established with a peer who would be available to review cases and provide the therapist with needed support and insights (also see the previous suggestions). Another alternative, with patient permission, is to videotape or audiotape sessions for review with a colleague.

■ *Arrange weekly team meetings or teleconferencing.* The FBT therapist should take charge in organizing scheduled team meetings or weekly telephone conferencing. In addition, the FBT therapist should ensure that everyone involved in the family treatment shares all relevant patient charts.

Summary

Published reports of manualized FBT show that it is effective for short-duration AN among adolescents. As a specific therapy, it has roots in

the rich tradition of family therapy and incorporates much from these approaches in a synthesis designed to address the developing adolescent in the context of the debilitating and life-threatening behaviors associated with AN. A manualized strategy helps properly prepared clinicians to keep focused on the role of eating-disordered behaviors in inhibiting, complicating, and disturbing the usual developmental processes of adolescence.

In this manual we present the FBT approach to AN in adolescents, which has both empirical and clinical support. By making this treatment available in a manual, we hope that more about its appropriate clinical use will be discovered by practitioners who embrace the methods described. We recognize that no treatment works for every patient or family under all conditions. Thus we believe instead that, other than in research studies in which strict protocols are needed, the judgment of individual clinicians should apply. This is no less true for FBT than for any other approach. Therefore, although we have endeavored to be as precise and specific as possible in the foregoing discussion, we recognize and fully expect clinicians to modify certain aspects of treatment to fit the circumstances in which they find themselves practicing. At the same time, there are certain principles of treatment that would hold, we believe, in every instance. Among these principles are (1) an agnostic view of the cause of the illness that holds the family not guilty from the perspective of treatment; (2) empowering parents as competent agents for ensuring weight gain in their starved offspring; (3) the view that the entire family is an important resource in recovery; and (4) a recognition that adolescent needs for control and autonomy in areas other than weight must be respected. We also believe that the pacing of the therapy should typically follow the overall guideline of the phases of treatment. That is to say, the focus of the initial period of treatment must be on weight restoration and normalization of eating under the control of the parents; not until these issues have been resolved is it advisable to proceed to Phases II and III.

We include an outline of therapeutic interventions by phase to help therapists see the pattern of the overall therapy, as well as to track their own cases (see Table 2.2). We hope that this will help the therapist who is using the manual to keep track of where he or she is in the treatment process and to follow the steps as outlined.