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Family-Based Therapy for Children and Adolescents with Eating Disorders

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Family-based therapy, also known as the Maudsley model, marks a significant departure from traditional approaches to treating eating disorders. In the history of treatment for anorexia nervosa, a “parentectomy” was thought necessary for recovery, because parents were seen to be the cause of the problem and likely to interfere with effective treatment. Current family-based therapy theories recognize that we do not know what causes eating disorders and that many factors contribute to their development. However, addressing such factors becomes useful only after eating disorder symptoms are no longer dominating family interactions. Throughout the recovery process, the family is the most important resource adolescents have in treatment, because they are uniquely

attached to their parents and siblings.

A number of controlled clinical trials studying family-based therapy with anorexia support its effectiveness: when treated early in the onset of anorexia 70 – 80% of adolescents (under the age of 18, living at home with parents) do well in weight-restoration, eating-related thinking and behaviours, and emotional and social functioning. Hospitalization can be minimized or avoided altogether and health can be restored within six months to a year, thereby minimizing disruption to the child’s physical, emotional, cognitive, and social development (Rutherford and Couturier, 2007). Studies examining the efficacy of family-based therapy with bulimia are in process.

Family-based therapy is an outpatient therapy with three phases: restoring weight so that it is consistent with that expected for the individual’s age and height, returning control over eating to the adolescent, and supporting the adolescent’s developing autonomy (Lock, et al., 2001).

Phase One: Weight restoration and/or symptom interruption

All members of the family living at home are urged to attend family therapy, including siblings. Because the family reorganizes itself around the illness, all members of the family are affected (Eisler, 2005). Each needs to understand what an eating disorder is and should know what roles they have in helping the ill child or sibling to get well. Parents often feel

themselves to be “walking on eggshells” and are angry, frustrated, guilty, and exhausted from trying to help their child while finding the eating disorder sometimes doesn’t budge or even gets worse. Siblings may be angry or feel guilty, too, and may withdraw from the family into school and friends, or may take on parental roles in trying to get their affected sibling to eat.

In the first phase of family-based therapy, the family learns how serious the eating disorder is: that left unchallenged it can lead to a life of disability or even to death (as it does eventually in up to 20% of cases (Cavanaugh, 1999). This view of the illness helps parents to take the stand that starvation is not an option and to begin the process of firmly and persistently supporting their child to restore weight and/or interrupt symptoms, with the therapist acting as a consultant and coach. The therapist helps the family remember that individually and as a group, they have many relevant skills and resources for the task ahead. Knowing they are the key to keeping their child alive and making her well, parents find strengths they never knew they had.

The therapist “externalizes” the eating disorder; that is, it is seen as separate from and as having overtaken the child/sister. However hungry she might be, if she eats normally, she will suffer the harshest criticism imaginable from the

eating disorder voice. However angry or frustrated the parents or siblings may be, their anger should be directed at the eating disorder, not at their child/sister. In other words, the adolescent is seen as being ill, rather than stubborn or disobedient, and is therefore not to blame and should not be criticized for her eating disorder symptoms. Neither however, should she be left alone to look after her meals, even though it would be developmentally appropriate to do so normally. She is not in control of the eating disorder behaviours and thoughts, and therefore needs her parents to take charge of nutrition and weight restoration by managing meals and disrupting symptoms such as food restriction, over-exercising, and purging. The focus is on restoring health.

Early in phase one, there may be a family meal in which parents are asked to bring a lunch for all family members, including a lunch that is sufficient to start reversing starvation in their ill child. Either at this meal or through discussions about meals, the therapist observes the impact of the eating disorder on the family’s interaction patterns around eating, and assists the parents in getting their adolescent to eat a little more than she or he was prepared to. The therapist coaches the family to recognize the “voice of the eating disorder”, to stay united against it, while also helping them to understand how difficult it is for the ill adolescent to challenge that

voice. The therapist helps the ill child recognize the difference between her own voice and that of the eating disorder.

At home, the parents’ task is to organize regular meals and snacks. At least one responsible adult must be present to provide the required amount of food and to support the adolescent to eat, and to prevent other symptoms such as exercising or purging behaviours afterward. Siblings can help with distraction, advice and encouragement, or supportive conversations, always being sure to avoid stepping into the parental role. The therapist predicts that if the parents are doing well with these tasks, then “things will get worse before they get better”. The eating disorder will direct all manner of nasty behaviour toward them through their ill child. She may call them names, scream at them, throw things, and so on. Parents may also start to question the validity of the treatment team’s recommendations. During this time, the therapist prepares the parent to view this process as evidence for positive change (Lask, 2000). Parents must remember not to engage with the eating disorder, to proceed persistently, firmly, and sympathetically in bringing the food their child needs to eat and sitting with her until she completes it. Food is the medicine their daughter requires and the doses must be taken fully. Every family will find its own way to deal with

situations that come up during this phase. For example, as things start to improve, a teen may ask to go to a pajama party at her friend's house. Some parents may say "no, not yet". Other parents may permit her to go, but only after she has had dinner with them and with the agreement that they will pick her up in the morning to come home for breakfast.

Phase one typically takes about ten weekly sessions that include medical monitoring and sometimes consultation with a dietitian. More sessions may be needed as this phase of refeeding remains the active focus until the adolescent accepts the parents' expectations at meals without significant struggle and is gaining weight steadily. When this occurs, parents typically experience an increase in effectiveness in the fight against the eating disorder. During phase one, family and developmental problems that are not directly related to eating disorder symptom management are purposely ignored to maintain the focus on weight restoration and symptom interruption. They are taken up when the eating disorder is no longer dominating family interactions.

Phase Two: Returning control of eating to the adolescent

Phase two is a process of returning food and weight control to the teen and negotiating adolescent issues that may have been part of the

development of the eating disorder. For parents this phase carries a tension between nurturing their adolescent's resumption of control of food intake and continuing to ensure that weight gain continues to full restoration (along with resolution of other symptoms). As long as the eating disorder continues to be managed, they will be encouraged to support their child's re-engagement in social or other activities that were dropped due to the eating disorder. The therapist guides this process, encouraging parents to work out resolutions to the challenges that come up at this time. For instance, a teen might want to go on a date that includes dinner. Parents could agree to the date but ask the teen to review the restaurant menu with them and show them what she is planning to order. With the adolescent, the therapist continues to highlight the difference between her own ideas and needs and those of the eating disorder, helping her to strengthen her own voice and her motivation to continue getting well. During this phase of about six weekly or bi-weekly sessions, medical monitoring continues and the therapist is cautious about a sub-optimal plateau of weight or a relapse that would signal the rejuvenation of the eating disorder and require a renewal of meal supervision. Siblings are encouraged to continue supporting their sister when needed. It is normal to vacillate between phase one and phase two tasks for some time.

During phase two the therapist

also helps the family to explore relationships between issues that may have been factors in the development of anorexia in their child, for example, body image issues that may re-emerge as weight is restored or symptoms curtailed, dealing with social pressures from peers to drink or use drugs, academic pressures, or family communication issues.

Phase Three: Supporting the adolescent's developing autonomy

Phase three is initiated when the adolescent has reached the weight her body requires, her weight is stable, and she is no longer in a self-starving mode of thinking. In the family context, the eating disorder is no longer defining family members' interactions with one another. About four meetings are held in this phase, occurring bi-weekly to once per month. The therapist helps the family anticipate issues that may come up in the near future, depending on the age of their adolescent, and models problem-solving. Issues of this phase may relate to identity-building and autonomy development, for example, social independence, sexuality, and leaving home for work or college. Parents are encouraged to begin re-organizing their life as a couple. They can do things they have not had the freedom to do together or begin projects they may have been putting off, for example, a parent going back to school to finish a

degree. Termination of therapy follows.

Key differences from traditional family therapy

In traditional family therapy, work with an adolescent would emphasize developing autonomy. Applied to an adolescent with anorexia, the therapist would advise parents to involve their child in meal planning, including choosing food types and amounts. The therapist might suggest that the child be allowed to prepare her own meal and to eat it wherever she feels most comfortable, even if that is alone. Parents would be encouraged not to respond to their child's requests for reassurance about food choices and not to comment on their child's eating behaviour. Parents would be coached not to disrupt dieting, exercising, or purging behaviours, but simply to ask their child to report any such symptoms to the treatment team. From a family-based therapy perspective, all of these approaches inadvertently empower the eating disorder, with the risk of compromising the child's growth and development.

Family-based therapy can be adapted for use in multi-family groups and in hospital treatment programs. Emotion-focused therapy is currently being developed as an adjunct to family-based therapy, particularly for use during phases two and three of the work. In those cases where family-based therapy is not proceeding well, a reflecting team approach may be

helpful. These subjects will be explored in future issues of the Bulletin.

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Additional Reading

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NEDIC News

NEDIC staff, students and volunteers wish our readers and clients a happy and healthy holiday season. Thank you for your ongoing support of our work.

The holiday season is often a very stressful period for individuals with food and weight issues and for those providing support. The emphasis on spending time with family and celebrating with food can be very distressing. Tips for coping with the holidays are posted on our website, www.nedic.ca.

We are proud to announce that our poster, *Stereotypes*, has won a Merit Award from the prestigious Art and Design Club of Canada. We thank Dwayne Morgan for giving us the wonderful image and Zulu Alpha Kilo advertising agency for donating their services in making it the striking poster that it is.

Eating Disorder Awareness Week is 1 – 7 February 2010. NEDIC is happy to advertise your local event on our website; contact us at www.nedic.ca with details.

Our EDAW 2010 poster carries one of the strongest messages about resilience to body image issues, and is now available for purchase. See our website Store for details.