

Family-based Treatment of Child and Adolescent Eating Disorders



Sarah Forsberg, PsyD*, James Lock, MD, PhD

KEYWORDS

• Eating disorders • Anorexia nervosa • Bulimia nervosa • Family-based treatment

KEY POINTS

- Twelve-month prevalence rates of eating disorders (EDs) among adolescents are as high as 2.6% in bulimia nervosa (BN) and 1% in anorexia nervosa (AN), with subthreshold presentations occurring at much higher rates.
- AN has the highest mortality of any psychiatric disorder and all EDs are punctuated by social impairment (loss of role functioning), psychiatric comorbidity, with high rates of suicide.
- Family treatment models, specifically family-based treatment (FBT) is the best evidence-based approach for adolescents with AN.
- FBT is a parental-empowerment model that supports parents in disrupting the harmful behaviors that maintain the ED.
- Preliminary data from systematic research support the use of FBT in the treatment of adolescent BN.

Eating disorders (EDs) have long been treated in a family context and inclusion of family members in therapeutic interventions of these adolescents is considered best practice.^{1,2} This recommendation highlights an important paradigm shift away from the early view that parents were the worst possible attendants in caring for their child with anorexia nervosa (AN), because they are now considered a central resource in bringing about recovery.³ As early as the 1970s, many family therapists took interest in the family dynamics that were thought to maintain the presence of AN. For example,

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Department of Psychiatry and Behavioral Sciences, Stanford University, 401 Quarry Road, Stanford, CA 94305, USA

* Corresponding author.

E-mail address: sforsberg@stanford.edu

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Abbreviations

AN	Anorexia nervosa
BN	Bulimia nervosa
CBT-GSH	Guided self-help version of cognitive behavior therapy
ED	Eating disorder
EE	Expressed emotion
FBT	Family-based treatment
FBT-BN	FBT manualized for bulimia nervosa
SPT	Supportive psychotherapy
SyFT	Family systems therapy

Salvador Minuchin, the founder of structural family therapy, viewed the manifestation of AN as a means of supporting the maintenance of pathologic processes characterizing so-called psychosomatic families. Familial patterns of overprotectiveness, rigidity, enmeshment, and conflict avoidance were putatively addressed in part by restoring intergenerational boundaries and establishing effective conflict management.⁴ Minuchin and colleagues⁴ were the first to publish findings suggesting that family therapy could be helpful for adolescent AN, and their report of success with most of their patients generated interest in further exploration.

An alternative view of family treatment of adolescent AN was based in the Milan school of systemic family therapy developed around the same time by Selvini Palazzoli.⁵ The therapeutic stance in systemic family therapy is nondirective and promotes family exploration and autonomy in identifying changes. This approach is thought to circumvent family resistance to outside interventions, allowing the therapist to join the family in a supportive role. Other schools of family therapy also contributed to the development of a specific family therapy model for adolescent AN, including strategic family therapy⁶ and narrative family therapy.^{7,8}

These early family models provided the groundwork for the development of what is now called family-based treatment (FBT). The approach was developed at the Institute of Psychiatry and integrated structural, systemic, strategic, and narrative family therapy elements that were thought to be practical in their application to AN.⁹ Although early models of family therapy are a far cry from the pathologic view of families that encouraged so-called parentectomy, both structural and strategic theory insinuate causality, even though this is not directly communicated. In contrast, a central tenet explicitly stated in FBT is that families are not to blame for their child's AN, and are instead considered the most helpful and positive resource in bringing about recovery. Thus, the therapist works to shift the family's focus away from causal mechanisms of AN, and must externalize and maintain an agnostic perspective throughout treatment themselves.

FBT^{10,11} is a manualized treatment. At its core, FBT empowers parents to directly manage ED behaviors (eg, excessive exercise, dietary restriction, purging, and binge eating) that maintain AN. This treatment includes positioning parents as authorities on their child, with the therapist serving as consultant around the nuances of AN. Family structures are only modified if they interfere with parental ability to support their child in gaining weight.

The application of FBT has predominantly focused on individuals with AN; however, given the significant overlap in symptoms across ED diagnoses, more recent efforts have examined its utility in treating adolescent bulimia nervosa (BN). Although individuals with BN tend to present to treatment at a later average age than their AN counterparts, they too are typically nested in the family.¹² FBT manualized for BN (FBT-BN) largely draws on the theory outlined for AN. Thus, parents are encouraged to use strategies

that arrest binge eating and purging behaviors. BN is more ego dystonic and distressing to the adolescent, whereas AN is often experienced as consistent with the person's identity, therein challenging healthy decision making and requiring significant parental control. The difference in presentation of BN thus necessitates a collaborative process between the parent-adolescent dyad. These modifications are outlined in detail in a manual published by Le Grange and Lock¹³ and are further elaborated later.

EMPIRICAL FINDINGS ON FAMILY-BASED TREATMENT OF EATING DISORDERS

Family-based Treatment of Anorexia Nervosa

Despite the long-standing tradition of studying family process and treatment of EDs, the empirical support for this practice is sparse. However, most empirical studies of adolescent AN have included variants of FBT in its current iteration, and, in light of this work, clinical guidelines recommend family treatment as a front-line approach.^{1,14}

There are 7 published randomized controlled studies of adolescent AN, all of which have included FBT. Compared with individual modalities, FBT shows better clinical outcomes, maintained across follow-up points.^{9,15–17} Data suggest that family therapy may confer a specific benefit to those with a shorter duration of illness (<3 years) and an onset before age 18 years.^{9,15} Individuals receiving FBT were less likely to need hospitalization and had lower rates of relapse at 1-year follow-up.^{16,18} In the largest trial to date, FBT was compared with family systems therapy (SyFT). Both groups achieved similar rates of remission in ED symptoms, but FBT promoted more rapid weight gain, required less hospital use, and was more cost-effective than SyFT.¹⁹ These preliminary findings provide strong support for continued exploration of family therapy with this group, and also suggest areas for enhancement or adaptation to serve those who do not respond.

Additional randomized controlled trials, open trials, and case series reveal important information about adaptations to FBT, dose, and special populations. FBT for adolescent AN has been shown to be effective when delivered in a shorter dose (10-session format delivered over 6 months vs 20 sessions delivered over 12 months); however, individuals from nonintact families, and those who are more obsessional about food and weight benefited from the longer format.²⁰ In cases of families with significant parental criticism directed at the adolescent (high levels of expressed emotion [EE]), seeing parents separately from their child promoted improved outcomes.¹⁸ However, recent data suggest that families with high EE can also be treated effectively in traditional, conjoint FBT.^{21,22} Further, FBT seems to be more successful in treating those individuals with higher eating-related psychopathology with obsessive-compulsive features, than individual treatment.²³ Individuals with comorbid psychiatric illness also show lower rates of remission and dropout in FBT.²⁴ Although younger age is a predictor of good outcome, age has not been found to moderate treatment outcome in existing trials, and results of a case series show similar positive effects of FBT for children aged 12 years and younger.²⁵

Family-based Treatment of Bulimia Nervosa

The empirical examination of the treatment of adolescent BN has been severely neglected. Only 2 randomized trials have been conducted to date, both including a form of family therapy. The first used a model of family therapy loosely based on FBT, in which families included any close other in the adolescent's life. There were no significant differences detected between those receiving family treatment compared with those in a guided self-help version of cognitive behavior therapy (CBT-GSH).²⁶ Primary outcome in BN studies is defined by abstinence from

binge/purge behaviors, and rates were comparable across treatment arms. The other trial compared FBT-BN with individual supportive psychotherapy (SPT). At end of treatment, subjects receiving FBT-BN had similar abstinence rates to those receiving family treatment in the Schmidt and colleagues²⁶ study and FBT was statistically superior to SPT. Further, FBT brought about greater improvement in all measures of core ED symptoms.²⁷ Follow-up studies designed to differentiate response to FBT among patient subgroups have collected preliminary data (Table 1).

IMPLEMENTATION OF FAMILY-BASED TREATMENT OF EATING DISORDERS

Family-based Treatment of Anorexia Nervosa

A set of fundamental assumptions underlies all therapeutic interventions within FBT (Table 2). In summary, FBT posits that there is no known cause of AN. Therapists recognize that the cause of AN may exist somewhere in the intersection of a multitude of biological, social, and psychological factors with unknown relative influence. Most importantly, families are not to blame for the emergence of the disorder and the therapists must remain agnostic while helping the family to do the same. Second, AN is not under the control of the adolescent. As in disease models of mental illness, AN is treated initially as a medical condition with emphasis on addressing the serious medical consequences of the disorder. Parents are thus placed in charge of providing their child with medicine in the form of food in order to restore healthy organ functioning and cognition. This regressed and medically fragile state is seen as limited and, as health is restored, greater adolescent autonomy is negotiated as developmentally appropriate. Thus, conditions of the illness require externalization; as the family is supported in viewing the ED behaviors and emotional and social consequences of AN as endogenous to the disease, they are better equipped to separate the illness from their child. In this way, they may take control over the ED behaviors while supporting and reinforcing all signs of healthy development.

Adaptations for Bulimia Nervosa

Parental empowerment is thought to be critical to change in FBT for BN as in treatment of AN. Despite similarities between these disorders, unique features of BN inform modifications to the model. Individuals with AN and BN are preoccupied with shape and weight to the extent that these become a primary focus of self-evaluation and drive compensatory behaviors. In AN, there is a significant discrepancy between reality (severe emaciation) and perception, whereas in BN this contrast is not as striking. These differences may in part explain the tendency for BN to feel dystonic to an individual's sense of self, and thus highly distressing. In general, adolescents with BN experience significant guilt and shame around bingeing and purging behaviors, and the lack of success in controlling their weight through dieting. These emotions often precipitate increased withdrawal from friends and family, thus strengthening the illness in its isolation. Similar to AN, although typically to a lesser degree, individuals with BN may minimize the seriousness of their illness, further impairing their ability to manage symptoms independently of parental support. As in FBT-AN, therapists are in a consultative role, providing significant psychoeducation with the aim of absolving the adolescents of responsibility for their actions, and alleviating family guilt and shame. The primary difference is the extent to which the adolescent is invited to join parents in collaborating around efforts to disrupt binge eating, purging, and irregular eating patterns. Adolescents with BN are typically viewed as more on track developmentally, with a greater degree of insight. Their

Table 1 Outpatient psychotherapy trials of family treatments for adolescent AN and BN				
Trial	Treatment Type	N	Mean Age (y)	Outcome
Adolescent AN				
Russell et al, ⁹ 1987	Family therapy vs supportive individual therapy	21	15.3	^a Family therapy, 90% ^b Individual, 18%
Le Grange et al, ¹⁸ 1992	Whole family vs separated family therapy	18	15.3	^a 68% overall; no differences between groups
Robin et al, ²⁸ 1999	Family therapy vs individual therapy	37	13.9	^a Family therapy, 81% ^b Individual therapy, 66%
Eisler et al, ²⁹ 2000	Whole family vs separated family therapy	40	15.5	^a 63% overall; no differences between groups
Lock et al, ²⁰ 2005; Lock et al, ³⁰ 2006	Family treatment (FBT), 6-mo vs 12-mo dose	86	15.1	^a 96% overall; no difference in weight change or psychological change between groups at end of treatment or 4-y follow-up
Lock et al, ¹⁶ 2010	Family therapy (FBT) vs individual therapy (AFT)	121	14.4	^a FBT, 89% ^b AFT, 67% ^c Full remission EOT: FBT, 40% AFT, 19% 1-y follow-up: FBT, 50% ^b AFT, 20%
Agras et al, ¹⁹ early view	FBT vs family systems (SyFT)	164		^c EOT: FBT, 33.1% SyFT, 25.3% ^c 1-y follow-up: FBT, 40.7% SyFT, 39%
Adolescent BN				
Schmidt et al, ²⁶ 2007	Family therapy vs CBT-GSH	85	17.9	^d Family, 26% CBT-GSH, 42%
Le Grange et al, ²⁷ 2007	FBT vs supportive individual therapy	80	16.1	^d FBT, 40% Individual, 19%

Abbreviation: EOT, end of treatment.

^a Outcome defined as rates of individuals meeting Morgan-Russell good/intermediate threshold (>85% of expected body weight in AN).

^b $P < .05$.

^c Full remission means greater than or equal to 95% of expected body weight.

^d Abstinence rates from binge/purge behaviors.

Adapted from Lock J, Le Grange D. Treatment manual for anorexia nervosa, second edition: a family based approach. New York: The Guilford Press; 2013; with permission.

Table 2
Principles of FBT for EDs

Principle	Goal	Related Interventions	Modifications for FBT-BN
Agnosticism	Decrease parental guilt; decrease blame Facilitate focus on current maintaining features of the ED	Highlight lack of causal data and dispel myths Emphasize evidence of successful outcome through disruption of symptoms rather than insight on cause	None
Symptom focus	Disrupt behaviors that maintain ED	Review weight progress/binge/purge frequency at outset of session Use data as guide for detailed discussion of successes and challenges in progress	Focus on normalizing eating patterns and decreasing binge/purge behaviors rather than weight restoration because individuals with BN are typically at normal weights
Consultative therapeutic stance	Increase parental alignment Increase parental self-efficacy	Encourage parents to work through solutions to current challenges Provide input as gathered through expertise on EDs (garnered through work with parents and research base) Assist family in understanding nutritional needs of their child	Adolescent may be more involved in problem-solving process as input is consistent with recovery-based goals
Parental empowerment	Reposition parents as authority on their child Increase parental self-efficacy	Place parents in charge of disrupting ED symptoms/meal management Reinforce positive steps taken to disrupt ED Frame challenges as opportunities to problem solve and adapt skill set	Adolescent may participate as appropriate in decisions about how to work on goals
Externalization of illness	Separate the illness from the patient Decrease familial criticism Align with intact healthy part of the adolescent	Use of Venn diagram to represent healthy characteristics/behaviors of the adolescent, ED-related characteristics and behaviors, and their overlap Encourage adolescent to consider both positive and negative impacts of the ED	Adolescent with BN may more easily separate the illness from their own sense of self (eg, they are more likely to view BN as egodystonic)

increased independence is acknowledged within the treatment; if regressed, maladaptive decisions regarding food and eating are highlighted as areas for increased parental intervention.

Structure of Treatment

FBT for AN typically takes place over the course of 10 to 20 sessions spaced over 6 to 12 months. As noted, shorter forms of FBT can be just as effective, and recent data suggest that weight gain (around 2–2.5 kg [4–5 pounds]) is the strongest identified predictor of recovery.^{31,32} Therefore, weight restoration in the home environment is a primary aim, and it is determined by evaluation of various data points (historical growth curves, normative growth curves, resumption of hormonal function and menses among girls).

For FBT-BN a typical course of treatment is 20 sessions over 6 months,¹³ with most time spent in phase I focusing on resumption of healthy eating patterns and decreased binge/purge behaviors. Success is determined by the therapist's ability to align parents in actively disrupting ED symptoms. The negotiation of parental involvement varies from family to family but often includes parental encouragement and provision of 3 meals and 2 to 3 snacks each day, parental monitoring and engagement in distraction after mealtimes, and temporary removal of binge foods from the home. Each session begins with a 10-minute to 15-minute meeting with the adolescent to obtain weight, assess frequency of binge/purge behaviors, and establish agenda items. Weight and binge/purge frequency are tracked on logs and shared with the family as markers of progress and challenge. Discrepancies between parent and adolescent reports of these behaviors are addressed as the log is shared when the family session convenes. In engaging the family in management of ED symptoms, the therapist is cautious in balancing efforts to align parents in a position of authority, while facilitating developmentally appropriate input from the adolescent. Recall that in treatment of AN the therapist is clear that they will not engage with the adolescent in negotiations about weight gain, a distinct difference between the two models.

Treatment Overview and Case Example

The following case example highlights key interventions and modifications to address challenges common to work with this population.

PRESENTING INFORMATION

Alexa is a Mexican-American 15-year-old with a 2-year history of AN punctuated by severe dietary restriction, occasional objective binges, ongoing self-induced vomiting, and excessive exercise. She had 2 previous hospitalizations for bradycardia and orthostasis, and was referred directly from an inpatient medical unit to the outpatient program. Her weight was below the 10th percentile for age and height; and she had a 1.5-year history of amenorrhea. The family of origin included her mother, grandmother, and 4-year-old brother.

Phase I Key Interventions

In the first session the therapist strives to accomplish the following tasks:

- Gather family history related to the impact of AN on the family
- Obtain history of the development of AN
- Orchestrate an intense scene surrounding the severe physical, social, and emotional consequences of AN to mobilize the parents
- Reduce parental guilt and blame
- Charge parents with the task of weight restoration of their child

- Externalize the illness
- Modify parental/sibling criticism
- Remain agnostic

Session 2: the family meal.

- Take a history of family meal preparation, serving, discussion
- Assist the family in understanding the nutritional needs of their child
- Align parents in their efforts to refeed
- Encourage the parents to assist their child in taking 1 more bite
- Keep the focus on AN and eating behaviors
- Align siblings in supportive role

The remainder of phase I continually incorporates the focus on parental empowerment, agnosticism, and externalization. In addition, the therapist:

- Provides ongoing feedback on weight and uses weight to guide in-session targets
- Directs therapeutic discussion toward food, eating, and their management
- Supports parental efforts at weight restoration

PHASE I CHALLENGES

From the first family meeting, it became clear to the therapist that Alexa's mother was experiencing guilt for being less available to Alexa after having returned to night school in addition to having a full-time job. In contrast, when Alexa refused to eat by leaving the table, screaming, crying, or threatening to run away, her mother quickly became critical, openly sharing her belief that her daughter was manipulating her in order to get attention. Thus, the therapist made significant efforts at the outset of treatment to redirect criticism toward the illness in its persistent grip over Alexa. He did this through assisting the family in creating a Venn diagram to illustrate the extent to which Alexa, who the family identified as empathic, an advocate for others, hard working, and a talented artist, had become overcome by AN (which they eventually called The Squid). This useful metaphor allowed the therapist to redirect family criticism quickly and refocus attention on developing strategies to disrupt behaviors that were maintaining AN (eg, endless bargaining about nutritional needs or family acquiescence in response to threats that she would throw up anyway after a meal). Given the family structure (single, working parent), and their limited financial resources, the therapist problem solved with the family to creatively identify sources of support. Alexa's mother was able to work with her school to take a leave of absence. Her grandmother was comfortable in the role of providing meals and readily increased the caloric density, often being the first to provide suggestions for meals. During meals, Alexa's mother and grandmother worked together, taking turns sitting with her in the midst of emotional outbursts, which required a firm, quiet, and patient presence. The family was able to practice responding to these challenges during the family meal session, whereby the therapist encouraged them to practice their own self-care to maintain the emotional resources required to consistently return their focus to refeeding once Alexa's distress had subsided. The mother and grandmother discovered and used their own language as a reminder to stay focused, persistent, and to express empathy, and would remind Alexa that, "We know how hard this is for you, and we cannot let The Squid tighten his grip; we will sit with you until you finish your meal." Further, the family realized that meals at relatives' homes were much easier, because Alexa was more compliant, and often more relaxed. The family scheduled meals outside of the home, and began to invite relatives and a neighbor to the home as Alexa became more comfortable.

Phase II Key Interventions

As the patient with AN begins to eat with more ease, allowing parental refeeding efforts without conflict, the family and therapist discuss readiness for phase II. Phase II generally does not begin until there has been sufficient weight progress (typically gaining to within 90%–95% of expected body weight).

Key interventions:

- Shape developmentally appropriate independence around eating, which might include the adolescent:
 - Selecting a part of the meal
 - Choosing between 2 equivalent snacks
 - Portioning with parental oversight
 - Eating a meal with a friend
 - Eating at school without parental supervision
 - Introducing some physical activity

Phase III Key Interventions

Readiness for phase III is determined based on attainment and stabilization of a healthy weight, as well as behavioral progress in resumption of independence around eating. Here the therapist assists the family in:

- Shifting the focus to developmental challenges and family concerns, which may include:
 - Dating
 - Schoolwork and time management
 - Peer relationships
 - Family conflict resolution and problem solving
 - Other concerning behaviors or comorbid psychiatric symptoms
- Encouraging family generalization of skills toward other non-ED challenges
- Reviewing a relapse prevention plan

CHALLENGES AND OUTCOME

Once the family learned that they could tolerate, and wait out AN outbursts, and modified the environment (requiring Alexa leave the bathroom door cracked after meals, requiring she sit with her grandmother or mother, having a family member sit next to her during mealtimes), AN slowly loosened its grip. The decrease in family criticism and strength in empathizing with Alexa's struggle allowed greater connection in moments when Alexa sought their support (which gradually occurred more frequently following difficult meals). The family began to engage in activities (going for short walks, playing board games, watching their favorite comedy) that allowed connection and a means of practicing emotion regulation following distressing meals. The therapist helped the family anticipate challenges that AN might present as they intensified their efforts, thus the family was not as surprised when they found that Alexa had been hiding food, and were able to frame this as being external to Alexa's control. Alexa responded well to rewards and looked forward to spending more time on her own with friends. Thus, early checks on independence included attending movies with friends and eating lunch on her own at school, instead of with a school nurse. When her weight decreased following introduction of minimal independence, the family regrouped and brainstormed strategies to support healthy independence without encouraging AN (asking a school counselor to check in with Alexa throughout lunch). In Alexa's case, the motivation to be on her own was often sufficient to overcome initial setbacks. As she gradually returned to full physical activity (first partial participation in physical education, the addition of brief walks with her mother, and eventually return to tennis practice) she began to struggle as her body required additional nutrition. Thus, the family increased supervision of an extra evening snack, as opposed to decreasing physical activity. Although Alexa expressed anger around having to again increase her intake, she preferred this to not being able to play tennis.

Toward the end of treatment, the family reflected on ongoing struggles (setting limits with regard to curfew, use of social media, and negative sibling interactions). The therapist provided education about typical adolescent development and normalized Alexa's increasing attempts at negotiation and pushing limits. The mother often saw Alexa's increased argumentativeness as a

direct attack on her, and in finding Alexa had lied to her on a few occasions, took this to mean her daughter did not respect her. Further, Alexa often took her mother's anger at her to mean she had failed more globally, leaving little space for acquisition of new skills. The therapist encouraged the family to engage in conversation rather than reverting to giving in or coming down too hard. The family found education about adolescent development informative, and over time their communication became less reactive and more exploratory, leaving room for negotiation and increasing autonomy. Further, the family worked to separate their fears about relapse from typical parental apprehension and concern about increasing independence. By the end of treatment (9 months, 22 sessions), Alexa had resumed a normal menstrual cycle, and was maintaining a weight that was on track with historical weight trajectories (40th body mass index percentile). Her ED cognitions emerged when exposed to foods she had first eliminated (sweets), as she expressed fear of bingeing, although since she began eating regularly she had not experienced objective binge episodes. Thus, toward the end of treatment, her family worked to gradually introduce these foods with greater oversight initially. Alexa was able to build mastery in eating these without feeling she lost control after regular exposures. By the end of treatment, although she struggled with occasional anxiety related to changes in her body, her interest and investment in peer relationships, exploring dating, playing tennis, and staying in school, coupled with strengthened family relationships and communication, were positive buffers against relapse.

Common Challenges

There are many common dilemmas therapists face in conducting FBT. Often, families and therapists alike become concerned about and/or distracted by the presence of comorbidity. In these instances, it is imperative for all parties to consider the extent to which symptoms of anxiety or depression, for example, are correlates of dysregulated or restrictive eating and their effects on energy, mood, and sleep. Therapists must provide a strong rationale to families for maintaining their focus on ED symptoms, with attention paid to comorbidity inasmuch as it interferes with restoration of health. Should threats to safety arise (eg, suicidal ideation or self-injury), the therapist will need to prioritize these concerns over eating disorder behaviors until they are resolved. In RCTs to date, AN patients with greater comorbidity were more likely to drop out of treatment (however to a lesser extent in FBT than individual treatment), and those with greater symptom severity (eating-related obsessions and compulsions) benefited from a longer course of treatment.^{21,30,33} However, even with significant rates of comorbidity seen in these RCTs, secondary diagnoses do not appear to differentially impact (moderate) treatment outcome.³⁴

Family differences (constitution, organization, and symptomology) warrant attention in FBT. An individual approach on occasion may be preferred in the context of high family criticism directed at the adolescent, as it has been shown to predict dropout in FBT.³³ When criticism toward the adolescent arises, the therapist prioritizes defusing, reshaping, and encouraging family use of externalization to reduce blame. In cases where a family presents a high level of expressed emotion (EE) in the form of criticism, separated FBT can be as effective as conjoint treatment.³⁵ Nonintact families are capable of meeting the demands of management of food and eating; however, therapists must often work harder to ensure these families have access to support. In the case of single-parent families, the therapist may engage more actively in the problem-solving and decision-making process, and often encourages parents to identify alternative supports (school nurses or counsellors, close friends, and other family members).

Evaluation of Outcome

Outcome in FBT for AN and BN is measured by examining eating disorder behavior, weight progress, and resumption of healthy physical function through medical

examination. In AN, the primary goal is full weight restoration and a return to premorbid growth and development. Full remission is defined as attaining a weight that is 95% of expected body weight for age and height.³⁶ It is also often important to consider previous growth patterns prior to development of the ED, as in some cases individuals may have tracked above or below the 50th percentile for weight. Early weight gain (approximately 4–5 pounds within the first month of treatment) is a good prognostic indicator of full recovery at the end of treatment for adolescents with AN. In BN, abstinence from binge/purge behavior is the primary indicator of full remission. In both groups, being able to maintain healthy eating patterns with parental oversight that is more developmentally typical is an indicator of a good outcome. In FBT, psychological recovery (absence of ED cognitions) is also a goal; however, it is not uncommon for these symptoms to persist beyond weight restoration, typically normalizing around 1-year later.¹⁷

Currently, adaptations to the standard dose of treatment are under consideration for adolescent AN for application with those individuals who do not make weight progress early in treatment. A recent observational study suggests that certain family behavior during the family meal session may help to identify those who may be challenged to progress and thus require adaptations or alternative treatments.³⁷ However, at this juncture, there are few convincing data to accurately predict who is likely to benefit from FBT; thus, therapists must use good clinical judgment, evaluating patient safety, symptom severity, and parental capacity in determining when to pursue alternative treatment models.

SUMMARY

FBT is the best evidence-based treatment of adolescents with short-duration AN. Although additional studies are needed to refine the understanding of FBT, improve response rates to FBT, and identify alternative treatment to FBT, therapists working with this age group should be familiar with this approach. In the case of adolescent AN, parental involvement in the weight restoration process with early weight gain seems to be critical, and shows improved rates of recovery compared with an individual approach designed to promote adolescent autonomy. In BN, support of FBT is more limited, but the approach seems feasible, acceptable, and effective.

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