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 colleagues[4] 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 therapy[6] 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