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Adolescent eating disorders & family therapy: an overview of current evidence-based treatments

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Family therapy has occupied a central role in the landscape of adolescent eating disorders for more than 40 years, with many rapidly evolving family therapy-based treatment advances offering an expanding scope of alternate treatment pathways. As such, we aim to provide an overview of existing evidence-based treatments for the family therapy-based treatment of a transdiagnostic array of disordered eating. In particular, we aim to summarize the most recent treatment advances, with a view to informing future directions in research.

KEY WORDS: Family therapy - Eating disorders - Anorexia nervosa - Bulimia nervosa - Evidence-based medicine.

Eating disorders remain amongst the most dangerous of all psychiatric disorders, demonstrating a notorious array of medical complications alongside a pervasive resistance to contemporary treatments, which have puzzled clinicians and researchers alike. Indeed, current outcomes with evidence-based treatment continue to fall short of the acceptable standards demonstrated in other psychopathologies,[1] and eating disorders are often characterized by a protracted and relapsing illness course.[2] However, recent research suggests that early intervention yields the most effective treatment outcomes,[3] which has resulted in an increased focus on the treatment of adolescent eating disorders, given that this is the most common developmental period of illness onset.

In glancing over the historical tapestry of adolescent eating disorder treatments, family therapy has been centrally implicated in innovative treatment interventions for more than 40 years, with structural,[4] systemic,[5] narrative,[6] multi-family,[7] and integrated [8] approaches to family therapy offering significant contributions to treatment development. Eating disorders were thought to offer family therapists a unique platform to index the efficacy of complex theoretical models, since the directly observable outcomes (*i.e.*, weight gain) offered a relatively straightforward method of indexing the complex interactional processes involved in treatment.[9] As a result, family therapy for eating disorders has amassed a relatively substantial number of controlled research trials, allowing for an

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unprecedented level of methodological rigor in analyzing family-based approaches to the treatment of adolescent eating disorders. This body of literature has resulted in an array of readily disseminable and empirically supported treatments.

Current treatment approaches

Family-based treatment

In the context of adolescent anorexia nervosa (AN), family-based treatment (FBT) has recently emerged as a highly promising therapy for medically stable adolescent presentations.[10] FBT represents a complex amalgamation of previous family therapy schools of thought, and was designed as an outpatient treatment which may be characterized by an agnostic stance towards the aetiology of AN, emphasizing the overarching tenet that parents posses the necessary skills and resources to restore their child to health.[10] However, given the overwhelming and anxiety-provoking presence of AN within families, many parents report feeling coerced away from their natural instincts as parents. This often results in an inadvertent level of accommodation to AN symptoms, which results in FBT working towards immediately empowering parents in overcoming any fear or anxiety around confronting their child's AN symptom profile. However, parental involvement may often be experienced by adolescents themselves as punitive and controlling, and FBT clinicians ought to ensure that the spirit of parental intervention is undertaken in a compassionate and non-blaming way,[11] given that perceived criticism is associated with treatment drop-out and poor treatment outcome [12] while parental warmth promotes good treatment outcome.[13] Further, in curtailing the potential for expressed parental toward the unwell offspring, FBT aims to "externalize" AN and conceptualizes the illness as external to family functioning and family members, which goes some way to allaying any internalised guilt amongst family members.[10] Further, attention is afforded to the unity of familial subsystems throughout treatment, with parental unity and sibling support being particularly important areas of focus throughout FBT.

The application of family-based treatment

FBT is separated into 3 distinct sequential stages of treatment, with each phase decreasing in intensity over the course of treatments which is usually provided over 9-12 months.

Phase 1

The first phase of FBT is characterized by the immediate mobilization of parental resources in curtailing the behavioural features of their child's AN, with parents being urged to focus exclusively on restoring their child's weight and intervening into their child's behavioural AN symptoms, such as restriction of particular food groups and compulsive exercise. The necessity for parental intervention is predicated on the ego-syntonicity of AN, alongside the magnitude of medical complications accompanying AN, and parental interventions necessarily take precedence over all other aspects of family and adolescent functioning. Clinically, this involves parents being encouraged to work together to collectively devise and administer strategies to ensure their child consumes an adequate volume and variety of calories, in addition to problem solving any AN-type behaviours which may inhibit their child's weight gain.

Phase 2

Once weight restoration and symptom remission is indicated, less parental authority is typically required in facilitating non-pathological eating practices, and adolescents may begin to demonstrate less resistance and more autonomy around eating, gradually returning to age-appropriate adolescent functioning. During this phase, parents may be encouraged to develop ideas around facilitating a gradual transi-

tion towards adolescent (age-appropriate) independence around food preparation and consumption whilst under increasingly less supervision, whilst weight is closely monitored to ensure no resurgence of weight loss.

Phase 3

Phase 3 typically commences when adolescents are able to independently demonstrate spontaneous and varied eating in a variety of contexts, whilst maintaining body weight [10]. During this phase, the focus of treatment shifts away from food and is reoriented towards any developmental issues which may have been impacted by the presence of AN, such as individuation, social and sexual relationships, and schooling concerns. Furthermore, clinical attention is also afforded to the collective resumption of pre-morbid family activities, in ensuring that each family member returns to their previous activities ad functioning once the crisis which AN presented has abated.

Further applications of FBT

Further to targeting those with AN, FBT has also been adapted to treat adolescent presentations of bulimia nervosa (BN), streamlining treatment in line with key clinical similarities and differences between AN and BN.[14] For instance, whilst taking into account the similar over-evaluation of shape and weight and the tendency to under-report symptom severity in both AN and BN, FBT for BN also acknowledges the reduced ego-syntonicity and enhanced motivation to reduce BN symptoms, resulting in a more collaborative parental stance to reducing symptomatology as opposed to the firm and direct parental stance adopted throughout FBT for AN. Furthermore, in light of many adolescents with BN falling within their healthy weight range, parental involvement typically centres around establishing stable eating, as opposed to ensuring rapid weight gain.[14]

In addition to BN, preliminary evidence suggests that FBT may also be adapted for the treatment of muscle dysmorphia,[15] which has recently been conceptualised as an eating disorder phenotype.[16-19] This adaptation featured a less central emphasis on weight, since those with muscle dysmorphia are not typically underweight, and focussed on the parental curtailing of the elimination of foods not deemed rich in protein, and compulsive muscle-building exercise regimen.[15] Furthermore, the core principles of FBT have also been adapted to the treatment of paediatric obesity, addressing the dual need for increasing independence and the sustained reliance on parent-influenced home environment in the context of non-psychiatric eating disorders,[20] although substantive empirical support is sparse.

Evidence-base for FBT

In the context of adolescent AN, FBT now represents the most well-researched treatment modality, with several randomized control trials,[3, 21] open trials,[22] dissemination studies,[23] mediator and moderator studies,[24] and meta-analyses,[25] consistently demonstrating promising rates of symptom remission and weight restoration for adolescents of short illness duration. For instance, approximately 50-75% of adolescents undergoing FBT may likely be weight restored by the end of the 12-month treatment intervention.[1] Furthermore, this weight restoration appears to be robust over time, with follow-ups at 6- and 12-months [3] indicating promising rates of continued weight restoration. Further, the weight restoration characteristic of FBT demonstrates an accelerated trajectory when compared to other adolescent-oriented treatments,[26] which is clinically highly significant when considering the pernicious medical sequalae of AN. In addition, the beneficial effects of FBT appear to be robust in a variety of contexts, with both conjoint and separated formats,[21] 6- and 12-month formats,[27] and even therapist-driven online formats [28] offering significant symptom remission.

In considering changes in typical AN thinking throughout FBT, the trajectory of cognitive remission remains somewhat less favorable than the trajectory of physiological and behavioural symptom remission. Approximately 40% of those undergoing FBT reporting a full remission of cognitive AN symptomatology by the end of treatment.[3] However, it should be noted that the remission of cognitive symptomatology in AN during FBT appears greater than in other forms of adolescent treatment.[3] Moreover, FBT appears to specifically offer benefit to those with more severe ED psychopathology,[24] and weight gain during FBT is directly related to the remission of cognitive symptomatology.[29] However, the disparity between physiological and cognitive recovery throughout FBT remains an ongoing challenge for clinicians and researchers. Recent efforts have attempted to locate the agents of change throughout FBT [30] and augment FBT based on the proposed agent of therapeutic change. However, the development of augmentative strategies ought not to corrupt the core principles of FBT, given recent evidence suggesting that the core tenets of FBT are directly related to adolescent weight gain throughout FBT,[31] and that perceived parental self-efficacy is predictive of adolescent outcomes throughout treatment.[30]

In the context of FBT for BN, fewer rigorously controlled trials have taken place. However, current evidence encourages the use of FBT as an effective treatment for adolescent BN, noting favourable outcomes when compared to supportive psychotherapy.[32] Further, FBT for BN demonstrates similar outcomes to cognitive-behavioural interventions, which is especially noteworthy given the established efficacy of CBT for adult presentations of BN.[33]

Alongside FBT for BN, recent preliminary evidence suggests that FBT may be adapted for the treatment of adolescent muscle dysmorphia,[15] although more controlled research trails are warranted before concluding as to the efficacy of FBT in muscle dysmorphia.

New directions in FBT

In light of empirical findings consistently demonstrating that many of those undergoing FBT report full symptom remission, ongoing empirical endeavours have been oriented towards augmenting the efficacy of FBT in instances when full symptom remission is not indicated. Indeed, emerging evidence suggests that overall treatment response may be reliably indicated within the first 4 weeks of treatment, with early weight gain being crucial in indicating likely outcome.[34, 35] These findings both 1) underscore the importance of early treatment progress, and 2) afford an early window at which likely treatment outcome may be indicated, informing clinical judgements as to whether augmentative measures ought to be employed. In addition, several key empirical findings have recently emerged, which may directly inform augmentative interventions.

Parent-focused treatment

Longstanding research demonstrates that families characterised by high levels of expressed emotion, parental criticism in particular, tend to fare less well in 'standard' family therapy.[12] As a result, preliminary research suggests that such families may attain better treatment outcomes in the context of separated family-based treatment, in which the parents are seen separately to the adolescent.[21] Further to these findings, more recent attempts have sought establish an entirely separated form of FBT, in which the FBT clinician sees only the parents, with nursing staff checking in with adolescents.[36] However, this treatment augmentation is pending empirical evaluation.

Collegial alliance

Recent research has suggested that collegial alliance between the multitude of colleagues involved in coordinating care for adolescents with AN may impact treatment outcome. Indeed, in the context of widely differing beliefs as to the role of

the family throughout treatment, and the high degree of anxiety necessarily elicited and mobilized throughout FBT, the propensity for splitting behaviours throughout FBT remains high.[37] As such, poor cohesion and inconsistency between treatment team members may undermine treatment efficacy, with preliminary data suggesting that the quality of collegial alliance may discriminate between those who drop out and those who complete treatment, and is also significantly related to the remission of cognitive AN symptomatology.[38] As such, future endeavours may seek to address the alliance between colleagues in augmenting the efficacy of FBT.

The therapeutic agent of change throughout treatment

In augmenting the efficacy of a given treatment modality, it has been deemed crucial to locate the precise agent of therapeutic change through the treatment is thought to exert its effect. To date, the atheoretical and agnostic nature of FBT has precluded a precise understanding of the agent of therapeutic change, and whilst recent evidence suggests that parental empowerment is more related to weight-related outcome than adolescent self-efficacy,[30] further evidence is needed to explicate the precise mechanism of how parental empowerment translates into symptom remission. Recent assertions have postulated theoretical accounts linking the agent of symptom remission throughout FBT to the theoretical framework of exposure and response prevention,[29] although empirical support remains sparse. Our group recently suggested that conceptualising FBT through the lens of exposure and response prevention may allow for theory-driven augmentations to FBT,[30] although empirical support is lacking.

Dissemination

FBT was initially conceived and conceptualized in specialist treatment centres as an outpatient treatment for medically stable AN, an important question has centred around the ease with which FBT can be effectively practised beyond the specialized treatment centres in which it was devised.[11] Whilst current evidence suggests that FBT can be effectively disseminated,[23] barriers may exist in the extent to which clinicians practising FBT ensure fidelity to the overall model.[39] For instance, lack of professional support within treatment centres, the difficulty in accessing specialized supervision, and clinician discomfort in working with families impinges upon the uptake of FBT in outpatient settings.[39] Further to outpatient settings, ongoing attempts are being made to adapt the theoretical principles of FBT to more intensive treatment settings, with clinically-driven recommendations outlining preliminary guidelines for the application of FBT in non-outpatient settings.[40] However, empirical support for the efficacy of FBT in the multitude of current non-outpatient settings is lacking.

Multi-family therapy

Uniting multiple families in the collective treatment of eating disorders has been practiced in specialist treatment centres in Europe for over a decade,[7, 41] and has been deemed especially suitable for the treatment of AN given the stigma and isolation which many families experience in helping their child recover from AN.[7] As noted in the treatment of other psychopathologies, uniting several families with shared concerns offers strong destigmatizing effects for those in treatment, creating a sense of solidarity which allays the frequently experienced sense of guilt and fear amongst those with eating disorders.[41] Indeed, multiple families sharing similar concerns in this setting allows for families to share advice between one another, acting as consultants to one another, deepening their sense of efficacy and agency.[7] This destigmatized forum for mutual sharing between families allows the therapist to further decentralize their role, focusing more on connecting families as opposed to directly intervening with individual families.[11]

The application of multi-family therapy

Whilst not yet standardized or widely disseminated, current guidelines posit that multi-family therapy (MFT) for eating disorders typically includes between 2-6 families.[7, 41] In its clinical content, MFT borrows from traditional FBT, structural, systemic, narrative and psychodrama practices, although all therapeutic practices are undertaken in a group format, with all families observing and providing feedback for one another. In terms of the broad overarching foci of treatment, MFT focuses on 1) parents and adolescents working together to develop temporary strategies to reduce eating disorder symptoms; and 2) fostering adolescent development which may have been arrested by the eating disorder. To this end, MFT typically follows a sequential 3-phase structure with each phase being of greater intensity than the subsequent phase. Phase 1 is exclusively oriented on symptom reduction, focusing on the establishment of parental authority in curtailing AN symptoms. Phase 2 typically commences after weigh restoration, and is oriented towards addressing relational issues within the family through a more systemic lens, focusing in particular on the role of AN within the family context. The third stage of MFT is oriented towards relapse prevention, both in terms of AN symptomatology and unhelpful familial interactions.

Evidence-base for MFT

Whilst still pending rigorous empirical evaluation, preliminary evidence suggests that MFT may be a promising alternative to FBT in the treatment of adolescent eating disorders. Indeed, MFT features uncharacteristically low rates of treatment drop-out, and is deemed helpful by both parents and adolescents alike.[7] Furthermore, preliminary reports suggest that MFT is helpful in bringing about early weight gain and symptom reduction,[42] although further research may seek to investigate the efficacy of MFT in controlled trials, and assess the dissemination of MFT beyond the specialised treatment clinics in which it was developed.

Intensive family therapy

Recent data suggests that one of the barriers consistently impinging upon the uptake of empirically supported family therapy-based treatments is the geographical sparsity of specialized treatment providers,[25] meaning that families in remote locations do not have access to leading evidence-based and specialized treatments. In partially meeting this gap in service provision, recent clinical endeavours have sought to develop short-term intensive treatment programs which allow for a time-limited immersion into specialist treatment programs.[43] These intensive family therapy programs (IFT) are typically conducted over a one week period, spanning 40 hours of treatment based on the core principles of evidence-based family therapy for eating disorders, and have been administered in individual [43] and multi-family formats. Whilst controlled empirical trails are not yet forthcoming, preliminary evidence suggests that IFT may offer significant symptom reduction in adolescent eating disorders.

Conclusions

We have witnessed significant advances in the family therapy-based treatment of adolescent eating disorders over the last decade, with the standardization and dissemination of treatment protocols in particular offering increased avenues for rigorously controlled empirical research. However, current family therapy-based approaches fall some way short of comprehensively treating all presentations of disordered eating in adolescents, and it is important that we periodically review current evidence and throw light upon emerging directions for research. Currently, an expanding number of alternate pathways

for familial involvement in the treatment of adolescent eating disorders are emerging, with many demonstrating promising preliminary evidence. However, further controlled empirical trails are warranted in determining the conditions under which each alternate variant of family therapy may operate most effectively, and how each variant may be augmented.

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