Helping Parents Help Their Kids: Understanding Family-Based Treatment

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Outline of this Presentation

① Family-Based Treatment Model
② Fundamental Assumptions
③ Three Phases of FBT
④ Common Concerns and Misconceptions
⑤ Family Video
⑥ Discussion
① Family-Based Treatment Model

The Maudsley Approach
Family-Bases Treatment for AN

Hospitalization

Traumatic

Disempowers Parents
Family-Based Treatment

- Developed at the Maudsley Hospital in London in the 1980s.
- Continues to be refined at Chicago, London, Melbourne, Mt Sinai, Stanford, Sydney and other centers.
- Takes key strategies or interventions from a variety of Schools of Family Therapy
  - Minuchin – Structural Family Therapy
  - Selvini-Palozzoli – Milan School
  - Haley – Strategic Family Therapy
  - White – Narrative Therapy
Family-Based Treatment

- Theoretically agnostic – no assumptions about the origin of the disorder, focus on what can be done.
- Parents are a resource with no blame directed to either the parents or the ill adolescent.
- Siblings play supportive role and protected from the job assigned to the parents.
Suitability and Context

- Appropriate for children and adolescents who are medically stable.
- Outpatient intervention designed to a) restore weight; and b) put adolescent development back on track.
- FBT is a team approach, i.e., primary therapist, pediatrician and child & adolescent psychiatrist.
- Brief hospitalization to resolve medical concerns.
What does FBT look like?

Adolescent Anorexia Nervosa
Treatment Style

Parents in charge
- Appropriate control
- Ultimately relinquished

Therapist stance
- Active – mobilize anxiety
- Deference to parents

Adolescent Respect
- Developmental process
- Traditional treatment upside-down
Treatment Detail

Dose
- 6-12 months

Intensity
- 10-20 sessions

Format
- Conjoint
- Separated
Three Phases of FBT

Phase 1
(Sessions 1-10)
- Parents in charge of weight restoration

Phase 2
(Sessions 11-16)
- Parents hand control over eating back to the adolescent

Phase 3
(Sessions 17-20)
- Discuss adolescent developmental issues
③ Fundamental Assumptions

Adolescent Anorexia Nervosa
Fundamental Assumptions

① Agnostic view of cause of illness (Parents nor adolescent are not to blame)

② Non authoritarian therapeutic stance (Joining with family)

③ Parents are responsible (Empowerment)

④ Externalization (Separation of child and illness)

⑤ Initial focus on symptoms (Pragmatic)
1. Agnostic

- No blame (but does not mean no responsibility)
- No guilt (but does not mean no anxiety)
- Therapist does not pathologize (either directly or indirectly)
- Do not look for cause of illness (etioloogy is not the focus of treatment)
Therapeutic Stance

- Serves as expert consultant
- Does not control parents or patient
- Therapist is active in treatment
- Most decisions are left to parents
- Supports therapeutic autonomy for parents
3. Empowerment

- Family is a RESOURCE for helping patient
- Most families CAN help patient
- Family has SKILLS to bring to the treatment
- Therapist leverages parental skills and relationships to bring about change (efficiency)
4 Externalization of Illness

- The adolescent is not to blame
- No pathologizing of patient (not regressed, immature, but rather ill)
- Respects independent status
- Supports increased autonomy with recovery
Initial Symptom Focus

- Emphasis is first on behavioral change (eating normally and not binge eating or purging)
- History-taking focuses on symptom development
- Delay of other issues until patient is less behaviorally and psychologically involved with AN
- No direct cognitive focus with adolescent
Effect of these tenets

- Highly focused, staged treatment
- Emphasis on behavioral recovery rather than insight and understanding or cognitive change
- This approach might indirectly improve family functioning
- Supports gradual increased independence from therapy
③ Three Phases of Treatment
What is the FBT

• Outpatient disordered eating program
• ~ Twenty sessions over 6-12 months
• Puts the PARENTS in charge of restoring normal eating patterns (appropriate control, ultimately relinquished), contrary to traditional clinical recommendation of “parentectomy”
Treatment Style and Format

• Therapist balances an active stance (appropriately mobilize parental anxiety) with deference to the parents’ judgment (empowerment)

• FBT has been studied in separated and conjoint formats (Separated tx perhaps better for high EE fam’s)

• FBT has been studies in short- and long-term format (six vs 12 months)
Prior to starting treatment

- Patient medically stable for outpt treatment
- Diagnostic interviews are completed and patient is appropriate for treatment
- Parents are reasonable candidates to help (live with the patient, not psychotic or substance dependent, no abuse)
- Parents agree to bring the entire family for treatment?
- Nutritional advice is not provided directly to the patient
④ Common Concerns and Misconceptions
Scared Parents
Scared Therapist

“You’re the therapist—you make it go away.”
Fitting Patients to Treatment

- Divorced parents
  - FBT assumes that the family eats together
  - Family = those persons living in the same household
    - May include non-biological parents
    - May exclude those not involved in day-to-day care

- Family psychopathology
  - Little data to support excluding parents
    - Parental discord
    - Parent with serious psychiatric/medical dx
    - Parent with ED
Fitting Patients to Treatment

- Single parent and single child families
  - Single-Parent
    - Therapist is important resource
    - Find additional adult ally (e.g., grandparent)
    - Treatment might take longer
    - Child parentified
  - Single-Child
    - Patient could feel unsupported
    - Therapist take on even more supportive role
    - Therapist has to balance support between parents and child
    - Role of friends
Fitting Patients to Treatment

- **Co-morbidity**
  - Mood disorder
    - Primary or secondary?
    - Medication?
  - Anxiety disorder, e.g., OCD
    - Primary or secondary?
    - Medication?
    - More treatment?

- Only acute suicidality trumps self-starvation
- Keep eye on the ball!
Fitting Patients to Treatment

- **Community Resources**
  - If you work outside a medical center
    - Therapy pairs
    - Establish relationship with another clinician
    - Weekly consultation
    - Weekly team meeting or teleconferencing

- **FBT in different settings**
  - If you work in an intensive treatment facility
    - Inpatient units
    - Partial programs
    - Residential programs
5 Family Video
Resources

Parent Case Book | Parent Handbook | Clinician Handbook

my Kid is back
EMPOWERING PARENTS TO BEAT ANOREXIA NERVOSA

HELP YOUR TEENAGER BEAT AN EATING DISORDER

Eating Disorders in Children and Adolescents
A CLINICAL HANDBOOK

edited by
Daniel Le Grange
James Lock
Resources

- Dissemination of Family-Based Treatment
  - Clinician Manual for AN (Lock & Le Grange, 2012)
  - Clinician Manual for BN (Le Grange & Lock, 2007)
  - Parent Handbook (Lock & Le Grange, 2007)
  - Parent Case Book (Alexander & Le Grange, 2009)
  - Clinician Handbook (Le Grange & Lock, 2011)

- Training Institute for Child and Adolescent Eating Disorders, LLC
  - www.train2treat4ed.com
⑥ Discussion