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### Family Interventions in Adolescent Anorexia Nervosa

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## History of the family's role in eating disorders

The view that the family has a central role in eating disorders can be traced at least as far back as the late 19<sup>th</sup> century. The views about the role of parents in anorexia nervosa (AN) varied from Lasegue's<sup>1</sup> relatively neutral stance in taking into account the "*preoccupations of relatives*", to Gull<sup>2</sup>, considering parents as "*generally the worst attendants*", and Charcot<sup>3</sup> thinking that their influence is "*particularly pernicious*". These early descriptions did not see parents as playing a helpful role in their daughter's illness, and indeed one of the earliest debates in the literature on AN was about whether it was at all possible to treat the patient without isolating her from her family<sup>4,5</sup>.

During the first half of the 20<sup>th</sup> century the family continued to be seen primarily as a hindrance to treatment<sup>6,7</sup> which together with a general notion that the family environment had at least a contributory role in the development of the illness<sup>7,8</sup> generally led to the exclusion of parents from treatment sometimes referred to pejoratively as a "parentectomy"<sup>9</sup>. It is not until the 1960's that we find a major shift in the thinking about the role of the family in eating disorders in the work of Hilde Bruch<sup>10,11</sup>, Mara Selvini Palazzoli<sup>12</sup> and in particular Salvador Minuchin and his colleagues at the Child Guidance Center in Philadelphia<sup>13,14</sup>. The theoretical models suggested by these authors, posited specific family mechanisms underpinning the development of AN which could be targeted by treatment. Thus the psychosomatic family model, developed by Minuchin et al<sup>14</sup>, hypothesizes that the prerequisite for the development of AN was a family process characterized by rigidity, enmeshment, over-involvement and conflict avoidance, which occurs alongside a physiological vulnerability in the child, and the child's role as a go-between in cross-generational alliances<sup>13,14</sup>. Minuchin did not place blame on the parents, highlighting the evolving, interactive nature of this process and emphasizing that the psychosomatic model was more than an account of a familial origin for AN. Nonetheless, Minuchin and his

colleagues still maintained that the psychosomatic family process is a necessary *context* for the development of AN and that the aim of treatment is to *change* the way the family functions.

This conceptual shift of explaining AN as being part of an evolving interactional family context had a profound impact on the development of treatments even though, as will be described later, the empirical foundation of the “psychosomatic family” model has been shown to be weak. The principal change arose from seeing the family as needing to take an active part in treatment in order to facilitate the change of some of the patterns of family interaction that had evolved around and had become intertwined with the eating problems. An important aim of the treatment model was to strengthen the parental subsystem in order to challenge what were seen as problematic cross-generational alliances and over-close, enmeshed relationships which were making it difficult for the parents to respond to their concerns for their daughter’s health in an active and united way<sup>15</sup>.

Since the early work of Minuchin and some of the other pioneer figures of the family therapy field, such as Selvini Palazzoli<sup>12</sup>, Stierlin<sup>16</sup> and White<sup>17</sup>, family therapy has gradually established itself as an important treatment approach for adolescent AN supported by growing empirical evidence for its efficacy. This development has undoubtedly been one of the important factors in the major changes in the treatment of eating disorders that the field has witnessed in the past 10 to 15 years<sup>18</sup>.

Paradoxically, alongside the data for the efficacy of family therapy, there has also been growing evidence that the theoretical models, from which the family treatment of eating disorder was derived, are flawed<sup>19,20</sup>. There has been considerable research endeavoring to uncover characteristics that are specific to families in which an offspring has an eating disorder and to test the specific predictions of the psychosomatic family model with generally disappointing and inconsistent findings<sup>21,22</sup>. There is a growing indication that families in

which someone has an eating disorder are a heterogeneous group not only with respect to socio-demographic characteristics but also in terms of the nature of the relationships within the family, the emotional climate, and the patterns of family interaction<sup>20</sup>. While there is some evidence that family therapy is accompanied by changes in family functioning<sup>23,24</sup> these changes are not necessarily in keeping with the psychosomatic family model and the changes may not apply consistently across all families. This inevitably brings to the fore the question of what the targets of effective family interventions should be and what processes underlie any resultant change. This has necessitated a second conceptual shift, away from an emphasis on a family etiology of the eating disorder towards an understanding of the evolution of the family dynamics in the context of the development of an eating disorder that may function as maintenance mechanisms<sup>19,25</sup>. This has gone hand-in-hand with the development of a much more explicitly non-blaming approach to family treatment for adolescent AN in which the family is seen not as the cause of the problem but rather as a resource to help the young person in the process of recovery<sup>19,26-28</sup>. Before describing the current approaches to family intervention in eating disorders we will review the existing evidence for their efficacy.

### **Uncontrolled open studies of family therapy for adolescent anorexia nervosa**

Over the past 30 years evidence for the utility of using family interventions for eating disorders has been steadily accumulating<sup>29</sup>. In their seminal work, Minuchin and his colleagues<sup>14</sup> describe the use of structural family therapy to provide treatment for adolescent AN. In their case series, the Philadelphia team reported a remarkably high recovery rate of 86% with their treatment approach. This was in stark contrast to the majority of the earlier accounts of treatment outcome with children and adolescents suffering from AN<sup>30-32</sup>. The patient population was mainly adolescent with a short duration of illness (mean ~ 8 months) that were treated largely on an outpatient basis although a proportion also required a brief

admission to a pediatric unit. These positive results, combined with the persuasive theoretical model that underpinned their approach, have made the work of the Philadelphia team highly influential despite the methodological weaknesses for which the study has been criticized<sup>33</sup>.

Two similar studies of adolescent AN, one in Toronto<sup>34</sup> and one in Buenos Aires<sup>35</sup> have been reported. Family therapy was the primary treatment, but a combination of individual and inpatient treatment was also utilized. The study reported by Martin<sup>34</sup> was of a five-year follow-up of 25 adolescent AN patients (mean age 14.9 years) with a short duration of illness (mean 8.1 months). Post-treatment data revealed significant improvements. A modest 23% of patients would have met the Morgan/Russell<sup>36</sup> criteria for good outcome, 45% intermediate outcome, and 32% poor outcome. Outcome at follow-up, however, was comparable to Minuchin's results with 80% of patients having a good outcome, 4% intermediate outcome, and the remaining still in treatment (12%), or relapsed (4%). Herscovici and Bay<sup>35</sup> report the outcome of a series of 30 patients, and followed-up 4-8.6 years after their first presentation (mean age = 14.7 years; mean duration of illness = 10.3 months). While 40% of patients were admitted to hospital during the study, 60% had a good outcome, 30% an intermediate outcome, and 10% a poor outcome.

A few other studies have utilized family therapy as the only treatment. A small number of adolescent patients were seen in out-patient family therapy at the Maudsley Hospital in London (n=12)<sup>37</sup> and at a General Practice based family therapy clinic in North London (n=11)<sup>38</sup>. Treatment was brief (< 6 months) and 90% of patients were reported to have made significant improvements or were recovered at follow-up. Stierlin and Weber<sup>16,39</sup> conducted a larger study and reported on families seen at the Heidelberg Center over a period of 10 years. Forty-two female patients with AN and their families were included in the follow-up. This study differed from the first two in that patients were older (mean age when first seen 18.2 years), had been ill for longer (on average > 3 years), and the majority had previous treatment

(56% of whom as inpatients). Therapy lasted on average less than 9 months and used few sessions (mean = 6). At a mean follow-up of 4½ years, just under two thirds were within a normal weight range and were menstruating. No distinctions were made between adolescents and young adults in the report and the findings are therefore not directly comparable to the other studies described above. Several more recent and larger dissemination studies of manualized family therapy for adolescent AN in the form of uncontrolled studies have been reported<sup>40-44</sup> which have produced comparable findings. In the only case series of family therapy for children with AN, Lock and Le Grange<sup>45</sup> demonstrated that this treatment is just as effective for these younger patients as it is for adolescents with AN. These studies all add to the evidence that children and adolescents do well in treatment when a family intervention is the main form of treatment.

### **Randomized controlled trials of family therapy for adolescent AN**

There have been a limited number of randomized controlled trials of family therapy for AN and all have been relatively small. In the first of these, Russell and colleagues at the Maudsley Hospital<sup>46</sup> compared family therapy with individual supportive therapy following in-patient treatment in 80 patients of all ages. Twenty-six of these were adolescents with AN, 21 had an age of onset on or before 18 years, and a duration of illness of less than 3 years. All patients were initially admitted to the hospital for an average of 10 weeks for weight restoration before being randomized to out-patient follow-up treatment. Adolescents with a short duration of illness fared significantly better with family therapy than the control treatment. Although the findings were inconclusive for those whose illness had lasted more than 3 years, these patients generally had a poor outcome. At 5 year follow-up<sup>47</sup> adolescents with a short history of illness and who received family therapy continued to do well with 90% having a good outcome. Patients who had received individual therapy also continued to

improve, however, nearly half still had significant eating disorder symptoms at follow-up.

Three subsequent studies compared different forms of family intervention. In the first two, Le Grange et al.<sup>48</sup> and Eisler et al.<sup>23</sup> compared conjoint family therapy (CFT) and separated family therapy (SFT) among a total of 58 patients. In SFT, the adolescent was seen on her own and the parents were seen in a separate session by the same therapist. Both treatments were provided on an outpatient basis. Overall results were similar in these two studies with patients showing significant improvements in both CFT and SFT (>60% were classified as having a good or intermediate outcome post-treatment), and relatively small differences between treatments in terms of symptom improvement. Families in which there were higher levels of maternal criticism tended to do worse in CFT. On the other hand, significantly more changes were demonstrated for CFT in terms of both individual psychological and family functioning<sup>23</sup>. Patients continued to improve after the treatment ended and at 5-year follow-up, the majority (75%) have a good outcome, 15% an intermediate outcome and 10% have a poor outcome<sup>49,50</sup>.

In a design similar to these Maudsley studies, Robin and colleagues<sup>51</sup> in Detroit, compared conjoint family therapy (behavioral family systems therapy - BFST) with ego-oriented individual therapy (EOIT) in 38 adolescents with AN. The latter comprised of weekly individual sessions for the adolescent and bi-monthly collateral sessions with the parents. In describing the features of BFST, Robin et al.<sup>51</sup> pointed out the similarities with the Maudsley conjoint family therapy. That is, both treatments emphasize the parents' role in managing the eating disorder symptoms in the early stages of treatment while the focus broadens in the later stages of treatment to include individual or family issues. EOIT is superficially similar to SFT although the aims are quite different. SFT emphasizes helping parents to take a strong role in the management of the symptoms while EOIT aims to help parents relinquish control over their daughter's eating and prepare them to accept a more

assertive adolescent. Despite these differences between EOIT and SFT, the similarities between them are equally important. Both treatments provided the adolescent with regular individual therapy in which she had the opportunity to address personal and relationship issues as well as matters directly related to her eating difficulties. While the parallel sessions with the parents differed in frequency and content, both treatments encouraged the parents to have an active and supportive role in their daughter's recovery and to reflect on some of the family dynamics that might have got caught up with the eating disorder.

Some notable differences between the Maudsley and Detroit studies could have had an impact on outcome. In Robin's study, patients <75% of ideal body weight (IBW) were hospitalized at the outset of treatment (almost half the sample) and remained in the inpatient setting until they had achieved 80% IBW. In contrast, the Maudsley studies<sup>23,48</sup> allowed for admission only if out-patient therapy failed to arrest weight loss (4 out of 58 were admitted during the study). Duration of treatment was shorter in the Maudsley studies (6-12 months) while the Detroit group spent between 12-18 months in treatment. Finally, patients at the Maudsley appeared to have been ill for longer, the majority had had previous treatment, and a higher percentage were suffering from depression.

Post-treatment results in the Detroit study demonstrated significant improvements in both treatments with 67% of patients reaching target weight and 80% regaining menstruation. Patients continued to improve, and at one-year follow-up, approximately 75% had reached their target weight and 85% were menstruating<sup>51</sup>. Physiological improvements (i.e., weight and menses) were superior for patients in BFST at post-treatment and follow-up. Improvements in psychological measures (i.e., eating attitudes, mood, self-reported eating-related family conflict) were comparable for the two groups. Robin et al.<sup>24</sup> also reported results of observational ratings of family interaction in a sub-sample of their study. They demonstrated a significant decrease in maternal negative communication and a corresponding

increase in positive communication in BFST but not in EOIT.

A small study by Ball and Mitchell<sup>52</sup> in Sydney compared the outcome of Behavioral Family Therapy and CBT in 25 13-23 year olds. At the end of one year treatment 72% had reached good/intermediate outcome (78% excluding treatment dropouts) but no differences were found between treatments. The results are difficult to interpret partly because of the small sample size and partly because patients who had to be admitted to hospital during the course of the study were excluded potentially biasing the results.

In a recent study Lock and colleagues<sup>53</sup> examined the effect of treatment dose of family therapy among 86 adolescents and found that a brief six month version of a manualized family therapy<sup>28</sup> was as effective as a year long version. However, the longer version of this treatment was superior for those patients who came from non-intact families or presented with higher levels of obsessions and compulsions about eating. At 4-year follow-up, and regardless of length of treatment, about two thirds of patients achieved healthy body weights and had Eating Disorder Examination scores within the normal range<sup>43,48</sup>

### *Summary of family therapy studies in adolescent AN*

Taken together, these studies consistently show that adolescents with AN respond well to family therapy, in many instances without the need for inpatient treatment. Between 50-75% of adolescents will be weight restored by the end of treatment. However, most will not have started or resumed menses. At 4-5 year follow-up, the majority (60-90%) will have fully recovered while only 10-15% will still be seriously ill. Outpatient family therapy compares quite favorably to other treatment modalities such as inpatient care where full recovery rates vary between 33% - 55%<sup>54,55</sup>.

Given the small size and number of comparative studies any comparisons between different kinds of family interventions ought to be interpreted with caution. Treatments that

promote parents to take an active role in tackling their daughter's AN seem the most effective and may have benefits over treatments where parents are involved in a supportive way, but are encouraged to step back from the eating problem. For instance, one study has shown that excluding parents from the treatment leads to a deleterious outcome and may even delay recovery to a considerable degree<sup>46,47</sup>. Seeing families in conjoint format appears to have the advantage in that both family and individual psychological issues are addressed. However, this form of family intervention may disadvantage families in which there are high levels of hostility or criticism<sup>56</sup>. Such families are perhaps more difficult to engage in family treatment<sup>57</sup>, a challenge that is exacerbated when the whole family is seen together. One reason for this might be that feelings of guilt and blame are increased as a consequence of criticisms or confrontations occurring during family sessions<sup>49</sup>. Our clinical experience suggests that conjoint sessions may be more useful for these families at a stage in treatment when the concerns about eating disorder symptoms have dissipated. It is important to note that while there may be relative merit between different types of family interventions, these differences are relatively small especially when compared with overall improvements in response to any of the family interventions studied.

Several reviewers recently concluded that there is compelling evidence for the effectiveness of family interventions for adolescent AN<sup>18,29,58</sup>. Given the status of current evidence, albeit limited, family therapy is probably the treatment of choice. Our enthusiasm for this treatment should be tempered in that the positive findings may, at least in part, be due to the lack of research on other treatments. Ego-oriented, cognitive and psychodynamic treatments are described in the literature<sup>51,59,60</sup> but with the exception of ego-oriented therapy and the small RCT of CBT vs family therapy<sup>52</sup>, these treatments have not been systematically evaluated with adolescent AN. Likewise, there is no systematic evidence as yet for the effectiveness of multiple-family day treatment, a promising new treatment development

described in some detail later on in this manuscript. Our knowledge of potential contraindications for the use of family treatment is limited but clearly caution is needed in cases where the patient's weight is extremely low (e.g., percent ideal body weight below 75), where there is severe parental psychopathology and there is evidence that where there are high levels of criticism or hostility directed at the affected offspring engaging the family in treatment is more difficult<sup>57</sup> and treatment outcome is worse<sup>23,50</sup>. However, more systematic evidence is needed to clearly delineate which families stand to benefit most from this treatment.

### **Theoretical model of family intervention in adolescent anorexia nervosa**

While the role of the family environment in the etiology of eating disorders is unclear, there is less doubt that the presence of an eating disorder has a major impact on family life<sup>61</sup>. With the passing of time, food, eating, and the concomitant concerns begin to saturate the family fabric. Consequently, daily family routines as well as coping and problem solving behaviors are all affected<sup>19</sup>. Steinglass and his colleagues described a similar process in families with an alcoholic member<sup>62</sup> and in families coping with a wide range of chronic illnesses<sup>63</sup>. They proposed that families go through a step-wise reorganization in response to the challenges of the illness. In their model, the illness and its associated issues increasingly take centre stage, altering the family's daily routines, their decision-making processes and regulatory behaviors, until the illness becomes *the central organizing principle* of the family's life. Steinglass et al. argue that when families attempt to minimize the impact of the illness on the sufferer and other family members, they increasingly focus their attention on the present. As a result, it becomes difficult to meet the families' changing developmental needs.

The proposed model is readily applicable to eating disorders. Families trying to deal with an eating disorder will often report that it feels as if time has come to a standstill and

that everything in their life has come to be focused on the eating disorder<sup>64</sup>. The way families respond to this will vary depending on the nature of the family organization, the family's style, and the particular life-cycle stage they are at when the illness occurs. What may be more predictable is the way in which the increasing emphasis on the eating disorder magnifies certain aspects of the family's dynamics while at the same time narrowing the range of their adaptive behaviors<sup>19</sup>.

Trying to disentangle which family processes may have a contributory causal effect, which are responses to the problem or which are just incidental is difficult. Moreover, as a number of authors have argued recently<sup>25,65</sup>, understanding mechanisms that maintain a disorder are likely to be of more utility for the development of effective treatments than the pursuit of etiological explanations. From a clinical perspective this requires joining the family in an exploration of how they got caught up in the eating disorder and to help them uncover some of their strengths so that they can disentangle themselves from the problem and discover new solutions. Most crucial in the process of engaging families in treatment, is to emphasize that they are part of the solution and not the problem. During treatment families may find that there are ways in which they function that they want to change. However, this is only secondary to the primary goal which is to overcome their child's eating disorder<sup>19</sup>.

### **The stages of treatment of family intervention for adolescent anorexia nervosa**

The practical application of family-based treatment for adolescent AN (FBT-AN) has been well described<sup>19,26,27,66</sup> the most detailed version being available now in a manualized version for clinicians<sup>28</sup>. In addition, a handbook to assist and guide parents through treatment has also been published<sup>67</sup>. This manual depicts FBT-AN as problem-focused in nature where the primary strategy is to bring about behavioral change through unified parental action. The family is held in a positive light and is seen as a significant resource in the adolescent's

weight restoration and concomitant return of normal eating and health. FBT-AN does not focus on the potential origins of the disorder, in fact, it takes an agnostic stance in terms of etiology while families are reassured that they are not the cause of the eating disorder. To mobilize parents to a unified stance, and to encourage the adolescent's cooperation, this treatment aims to externalize and separate the AN pathology from the affected adolescent<sup>68</sup>.

FBT-AN has been described as having a number of distinct phases although in practice these often overlap. The first phase of treatment is mainly concerned with supporting the parents in their effort to restore their adolescent's weight. In order to achieve this goal, the therapist encourages the parents to present a united front directed toward weight restoration. At first, the adolescent's food intake is under parental control with the parents monitoring meals and snacks while restricting physical activity where necessary and taking an active role in limiting purging or other behaviors that can potentially lead to weight loss. Engaging the family in this task requires the therapist to be able to convey to the parents that, however impossible the task ahead may seem to them the therapist believes that they will eventually succeed. At the same time s/he has to show an understanding of the young person's fears while being clear that this must not deflect the parents' efforts of helping her get her life back on track even weight restoration has to be achieved despite frequent or considerable resistance on her part. The therapist provides liberal amounts of information to the family about the nature of eating disorders and physiological and psychological effects of starvation partly to help the parents gain a better understanding of the nature of the problem but also to reinforce the message that AN is a powerful illness and typically would not 'allow' the sufferer to make appropriate or healthy decisions regarding food and exercise. While encouraging the parents to work together at weight restoration, the adolescent is aligned with her sibling subsystem, i.e., siblings are placed in a supportive role while the task of weight restoration is exclusively the parents' domain.

The therapist does not prescribe a particular course of action to the parents. Instead, s/he will explore with the family how the parents have functioned outside of the illness context, what their particular strengths of each parent are, and how these could be used to explore weight restoration strategies best suited to their particular family. The first phase of treatment focuses almost exclusively on weight restoration and a return of healthy eating patterns. Consequently, the therapist emphasizes that this goal takes precedence over almost any other issue until the adolescent's self-starvation has been reversed.

The second phase of treatment begins when the patient has reached ~90% of ideal body weight, is eating without much resistance, and the mood of the family is more upbeat. It is at this time that the parents are guided to return responsibility over eating back to the adolescent. This process is both gradual as well as tailored to the age of the adolescent. Consequently, there may be few differences between phases one and two for an 11-year old where parents are typically still very much in charge of their child's food intake. A 17-year old, on the other hand, will be given much more responsibility and independence over her food choices. Once the parents have been able to negotiate the return of control over eating to their adolescent, topics that have been put on hold can now be explored. For instance, going to the movies with friends may now return to the agenda, but only inasmuch as the adolescent can continue to achieve a healthy weight.

The third phase of treatment usually begins around the time that the adolescent has achieved a healthy weight for age and height, one at which they are able to menstruate (for females). This part of treatment focuses the discussion on general issues of adolescent development and ways in which the eating disorder has impacted this process. FBT-AN views the eating disorder as having taken normal progression of adolescent development off-track. Once the adolescent is back on track, discussion can focus on the remaining developmental challenges and how parents can help their adolescent to navigate this process.

In keeping with an age-appropriate strategy, the focus of treatment at this stage is on increased personal autonomy, relationships with peers, or getting ready to leave home for the first time. The needs of siblings as well as parents which will also have been put on hold by the illness are also addressed at this stage. In the final stages of treatment issues about ending of therapy and relapse prevention strategies are also discussed.

### **Multiple-family day treatment (MFDT) for of adolescent anorexia nervosa**

Multiple family therapy (MFT), originally pioneered by Laqueur<sup>69</sup> in the treatment of schizophrenia as a way to utilize the combined resources of families to improve family communication, learn by analogy, and expand their social repertoires<sup>70,71</sup> has been adapted for work with various psychiatric populations<sup>72,73 74-76</sup> including eating disorders<sup>77,78</sup> The usual format of MFT is similar to most group therapies i.e. weekly or fortnightly meetings but more intensive formats have also been developed in which groups of families meet for whole days<sup>79</sup> sometimes over an extended period of time as part of a day treatment programme<sup>80,81</sup>. This more intensive format of MFT is proving to be particularly well suited for the treatment of adolescents with eating disorders and two groups in Dresden, Germany<sup>82</sup> and in London, UK<sup>83 84</sup> have been developing MFT day programmes which integrate the conceptual ideas of FBT-AN with MFT concepts.

Bringing several families together is a powerful therapeutic resource which helps to reduce the sense of isolation, diminishes stigmatisation, enhances opportunities to create new and multiple perspectives, but above all addresses the pervasive sense of helplessness which families experience when trying to deal with the AN in their daughter or son<sup>64,85</sup>. There are many similarities and overlaps between the individual work with families as described earlier and the multiple-family treatment approach. There are similar phases in both approaches with an early focus of helping the parents to take a strong stance against their child's anorexia

whilst remaining sympathetic to how terrifying this is for her. Later the focus of the group shifts to include individual needs of family members and the developmental tasks that may have been put on hold by the emergence of the eating disorder. The group is both the context for joint problem solving and a source of support when things seem unbearably difficult<sup>86</sup>.

The MFDT starts after the family has been engaged in treatment individually and they are invited to take part in a four-day intensive workshop with up to 5 other families. The treatment continues with additional one day group meetings and is supplemented by individual family sessions depending on the specific need of each family<sup>a</sup>. The four-day workshop provides an opportunity for a range of interventions, including whole group discussions, separate work with the adolescent group and the parent group with a range of intervention techniques being used including whole group discussions, role-playing, psychoeducational sessions, supported meal times, video feedback sessions etc<sup>33</sup>.

The intensity of multiple-family day treatment leads to a strong sense of group cohesion from early on and a highly collaborative relationship between the families and the clinical staff. This has been contrasted with what often happens in the context of in-patient units<sup>87</sup> where staff may view parents with some ambiguity due to their (staff) conscious or unconscious beliefs that the parents have failed and are perhaps even to blame for the child's eating disorder. This is often reinforced by the parents' own sense of failure. Sometimes this can lead to the view that it is necessary to separate the adolescent from her parents in order to assist him/her in their individuation<sup>60</sup>. In such a situation the staff and parents can be at odds as to who is the 'best' carer or alternately they may develop a shared belief that the hospital provides a better home. These dynamics can become easily entrenched particularly if rapid weight loss follows discharge from an in-patient unit, which serves to confirm that hospital staff are 'better' than parents and underscore the parents' failure. Consequently, demoralized parents are keen to sanction their child's readmission to hospital eager to have her discharged

later rather than sooner and the chronicity of the illness is only matched by the chronicity of the evolving dynamic of the staff/family relationships. The context of MFDT with its focus of using the group as the main arena for problem solving, is very different, similar in some ways to a therapeutic community. One of the strengths of the MFDT model is that it brings families together in a way that makes them feel empowered and allows them to draw on the expertise of the staff without needing to hand over to the experts<sup>33</sup>.

As is the case with Maudsley family therapy approach in general<sup>66</sup> MFDT aims to help parents rediscover their own resources and take an active role in their daughter's recovery. Families are encouraged to explore how it has become problematic to follow the normal developmental course of their family life-cycle by looking at how the eating disorder and the interactional patterns in the family have become entangled. Sharing experiences among families as well as the intensity of this treatment program sets it apart from the experience that is more typical of out-patient family therapy. In the context of multiple-family day treatment the emphasis on helping families to find their own solutions is readily apparent<sup>33</sup>.

Each group of families develops its own unique dynamic. However, almost all groups establish an identity that evolves around discussions of their shared experience of living with AN and the impact this has on family life. Parents of a child with AN often present with a complex set of. Meeting with other families provides an opportunity to share feelings such as failure, guilt, anger, fear and embarrassment experiences and a range of associated. This creates a sense of solidarity and helps families to feel less stigmatized. In multiple-family day treatment family members outnumber clinicians. Consequently, this numerical advantage also has the effect of making the adolescents and their parents less central. Rather, they are members of a large group and the feeling of being constantly examined is less pronounced. This process seems to accelerate the families' ability to externalise the AN and to join forces to overcome the eating disorder.

Getting to know other families that struggle with an eating disorder also accentuates differences between them. This in turn demonstrates for families that there is no specific family structure that leads to the development of AN, which makes it easier for families to compare how other parents handle their teen's food refusal. The effect of these comparisons allows families to consider fresh perspectives on their own dilemma. The mix of joint problem solving discussions, activity techniques and observing how other families deal with similar problems allows each family to find their own way of learning and moving on. The families are generally very respectful and supportive of each other while at the same time being willing to provide as well as receive feedback about each other which generally carries considerably more weight than if it were coming from the clinician who may be very experienced but does not have the shared experiences around food, dieting or hospitalization. The therapist's role is therefore, more of a catalyst encouraging interaction between families and creating a safe context which enables families to make connections with one another and facilitates mutual curiosity and feedback.

### *Preliminary findings*

The two teams in London and Dresden that have been developing MFDT have now had experience with several hundred adolescents with an eating disorder and their families using this approach. In addition a number of teams in the UK but also in other countries (Canada, Norway, Sweden, Denmark, Netherlands, Switzerland, Czech Republic, Hong Kong) have taken part in MFDT training and started running their own groups<sup>88</sup>. Feedback from both the families and the professionals who have taken part has been extremely positive and audit data have shown very low drop-out rates from treatment in both centers of between 2 and 3%. In Dresden, admission rates have been reduced by 30%, while the duration of inpatient treatment has been reduced by 25%, and readmissions have been cut by half<sup>29,87</sup>

Systematic follow-up data to demonstrate the effectiveness of multiple-family day treatment in bringing about symptomatic improvement are limited at this stage. A small study investigating the experiences of families of taking part in MFDT and early symptom change in 30 adolescents has been completed in London<sup>89</sup>. This has shown that by 6 months (i.e. half way through treatment) the average weight for height for the group was at the lower end of the normal range, with 21% of the adolescents being classified as having a good and 41% intermediate outcome on the Morgan Russell scales<sup>36</sup>. The most immediate and striking change comes from the qualitative evaluation of the families experience of the treatment. observed is the way in which families have come to be reinvigorated in terms of their ability to help their daughter. For many families this discovery is accompanied by meaningful reductions in disputes around eating and replaced by a more accommodating and compassionate atmosphere between the adolescents and their families<sup>33</sup>

## Summary

Almost all treatment models assume a specific mechanism of change (e.g. cognitive restructuring, changes in interpersonal relationships, etc) that are seen as the target of the treatment goal. However, the fact that different treatments often lead to quite similar outcomes would suggest that our understanding of the mechanisms of change remain limited<sup>90</sup> and it is likely that the actual mechanisms of change for different treatments will turn out to be quite different than is assumed by theory This is undoubtedly the case for family therapy for eating disorders as its history clearly shows. While the empirical evidence for the effectiveness of family therapy for adolescent AN is gaining strength, the theoretical models from which this treatment is historically derived have been shown to be wanting. Our understanding of the way in which family interventions bring about change still remains largely speculative and our involvement with families in the more concentrated atmosphere

of the multiple-family day treatment program that has among other highlighted how limited our understanding of the process of change leading to recovery is. Just as families differ in the way they respond to having a member who develops an eating disorder so they also differ in the way they utilize family interventions. Some very quickly take firm charge of their daughter's eating until she returns to a healthy state and for such families the opportunity for parents to re-establish appropriate parental authority is the main focus around which change seems to take place. Other families step into the domain of parenting only briefly or in a more symbolic way as if the confirmation that they could do this if necessary was all they needed. In yet other families, meeting together serves as a chance for the adolescent and the parents to start redefining the role the parents are going to have in relation to eating as well as other areas of adolescent life. The commonality in these solutions seem to be that families are able to take some distance and extricate themselves from the way they have been caught up with the symptomatic behavior. In this process, many families regain their belief that they can find a way of conquering the problem, even if this may take some time.

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<sup>a</sup> The MFDT programme developed in Dresden is somewhat different in that it has many more group follow-up days and unlike the Maudsley relatively little individual contact with families outside of the group meetings<sup>87</sup>