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A Brief, Intensive Application of Multi-Family-Based Treatment for Eating Disorders

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There is a continued need to improve upon the efficacy and availability of treatments for anorexia nervosa. Family-based therapy for anorexia nervosa demonstrates strong empirical evidence; however, trained treatment providers are limited and a subsample of participants receiving the treatment fail to respond. The intensive family treatment program is a brief, time-limited, multi-family program that trains families of adolescents with eating disorders to oversee their adolescents' recovery at home by providing psychoeducation, skills training, and immersive practice over the course of a 5-day period. This article provide a description of the program by summarizing underlying theoretical principles and key therapeutic components.

INTRODUCTION

With current treatments for anorexia nervosa (AN) failing to reach acceptable standards of treatment outcome (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007), the need for innovative treatment approaches is well established (Strober & Johnson, 2012). Amongst contemporary treatment approaches,

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family therapy approaches have amassed a particularly robust evidence base supporting their application in medically stable adolescent presentations of AN (Downs & Blow, 2013). Family-based therapy for anorexia nervosa (FT-AN) is a manualized family treatment (Lock & Le Grange, 2012) with a specific eating disorder focus, which centrally leverages parental and family resources in directly intervening into an adolescent's behavioral symptom profile. FT-AN demonstrates promising empirical evidence, in that up to 70% of patients are weight restored within a year of commencing treatment (Le Grange & Eisler, 2009), and up to 40% of patients are remitted of cognitive symptoms within a year (Lock & Le Grange, 2012).

However, an ongoing challenge of specialized family-based therapy approaches pertains to their widespread dissemination, with a noted scarcity of trained specialists beyond the academic treatment centers in which they were developed (Murray, Labuschagne, & Le Grange, 2014). Currently, the lack of specialized family therapists inhibits the dissemination of these treatments, with both families and clinicians alike noting how the scarcity of specialist providers inhibits treatment access for families and precludes supervised treatment uptake by clinical practitioners (Couturier, Kimber, & Szatmari, 2013).

In response to these barriers, recent endeavors by our group have sought to establish short-term intensive treatment programs, which allow temporary immersion into otherwise inaccessible evidence-based treatment programs, with preliminary reports suggesting promising findings (Marzola et al., 2015; Rockwell, Boutelle, Trunko, Jacobs, & Kaye, 2011). Initially, these short-term intensive treatments were developed for individual families (Rockwell et al., 2011), although recently have evolved into a more cost-effective multi-family format (Marzola et al., 2015), demonstrating promising outcomes comparable to both outpatient FT-AN (Lock & Le Grange, 2012) and intensive family therapy for individual families (Rockwell et al., 2011). However, alongside the emerging empirical evidence supporting intensive multi-family therapy, it is important that the clinical content of this approach is outlined such that dissemination and widespread implementation is facilitated. Thus, we aim to comprehensively outline the nature of the intensive multi-family therapy program developed at the University of California, San Diego.

PROGRAM DESCRIPTION

The program is intended to provide an immersive treatment experience and psycho-education for families. The treatment is delivered to children and adolescents with eating disorders and their families over 5 days. Treatment is conducted with up to six families and delivered in an intensive format, with families receiving approximately 9 hours of treatment per day,

for a total of 40+ hours of treatment delivered over the course of the week. The program is run in a multi-family group format, such that parents, patients, and other attending family members participate conjointly in the majority of groups. Other components include daily parent-only and patient-only group sessions, and individual family psychiatric and medical evaluations. Multi-family intensive family treatment (IFT) is deemed suitable by families and has demonstrated preliminary efficacy for patients with a broad range of ages (8–27), eating disorder diagnoses (Marzola et al., 2015; Rockwell et al., 2011), and phases of treatment. This heterogeneous group composition serves a number of diverse patient needs including supporting transitions between phases of treatment or levels of care, augmenting traditional individual therapy, and as a booster for patients failing to make gains in outpatient care.

IFT is based primarily on the underlying theoretical principles of FT-AN, which draws on broad systemic family therapy principles with a central focus on conceptualizing parents as a necessary and critical resource in facilitating recovery through managing early eating disorder behavior change (Dare, Eisler, Russell, & Szmukler, 1990; Eisler, Wallis, & Dodge, 2015; Lock & Le Grange, 2012). The overarching goal of IFT is to educate, train, and prepare parents to effectively manage the recovery of their child upon the transition to home-based management whilst motivating the young person to accept their parents help to return to normal adolescent functioning. Accordingly, the program employs treatment strategies and psychoeducation that are focused on mobilizing parents to engage their teen in recovery-oriented behaviors.

Alongside this family systems approach, the guiding principles underlying IFT are also rooted in a contemporary understanding of the neurobiology of eating disorders. Thus, IFT treatment strategies frame eating disorders as neurobiologically-driven illnesses, which assists families in viewing the illness as medical problem, thereby reducing blame and increasing empathy. In addition, the etiological emphasis allocated to neurobiology allows for treatment strategies to become increasingly congruent with the temperamental and personality-based correlates of those with eating disorders. For instance, IFT treatment strategies have been constructed and/or adopted in response to the recognition that patients, and frequently their family members, exhibit high levels of anxiety and harm avoidance, difficulty with tolerating uncertainty, interoceptive deficits, and altered responsivity to reward and punishment (Kaye, Fudge, & Paulus, 2009; Kaye, Wierenga, Bailer, Simmons, & Bischoff-Grethe, 2013). The perspective that eating disorders emerge as a function of a specific neurobiology is complementary to the FT-AN model because both emphasize the importance of dispelling blame and using existing family and individual characteristics as strengths to overcome the disease. The neurobiological perspective and the FBT approach thus have mutual positive benefits and together make up the

general philosophy underlying the IFT model. In keeping, IFT consists of six primary treatment components with very specific aims. These components form the foundation of treatment, with all exercises and activities conducted throughout the program falling under the umbrella of one or more of these components. The six components include family therapy, supervised family meals, parent management training, behavioral contracting, patient skills training, and psycho-education.

TREATMENT FORMAT

Multi-Family Format

IFT is modeled on multi-family therapy for eating disorders, where multiple families are treated simultaneously in a group format (Dare & Eisler 2000; Simic & Eisler, 2015). Despite the relative novelty of multi-family treatment for eating disorders, the approach has an extensive history (Asen, 2002), and has been successfully applied to a number of child and adolescent issues, where parent involvement is critical (McKay, Harrison, Gonzales, Kim, & Quintana, 2002; Saayman, Saayman, & Wiens, 2006). Delivering family therapy in a group format appears to enhance the uptake of FT-AN principles, as well as accelerate necessary change and movement towards recovery (Salaminiou, 2005; Voriadaki, Simic, Espie, & Eisler, 2015). For instance, families serving as consultants to each other allows for a greater development of agency as opposed to when therapists serve as consultants, and allowing for further decentralization of the role of the therapist (Murray et al., 2014). Indeed, the synergistic effect of combining group and family modalities increases the opportunities for learning and change amongst family members by allowing learning to take place from other attending families through direct observation, comparison, and consultation (Asen & Scholz, 2010). A recent multi-center RCT comparing single-family and multi-family treatments for eating disorders showed that multi-family treatment was more effective at post-treatment and early follow-up (Eisler, 2013).

Brevity and Intensity

The intensive nature of IFT is one of the unique features of this program, where families receive approximately 40 hours of treatment over the course of 5 days. Intensive models of treatment have been utilized extensively in the treatment of a range of anxiety disorders (Davis, Ollendick, & Öst, 2009; Mörtberg, Karlsson, Fyring, & Sundin, 2006; Whiteside, Brown, & Abramowitz, 2008; Whiteside & Jacobsen, 2010). Similar to intensive family-based treatment programs for anxiety disorders, IFT participants benefit from the ability to receive massed practice and in-vivo therapist-guided training

on key factors involved in recovery. Real-time therapist observation and intervention during target events such as mealtimes, acute emotional outbursts, and family interactions allows parents to receive practical, hands-on training and management skills.

PRIMARY THERAPEUTIC COMPONENTS

The comprehensive IFT model provides training in parent management of the illness in line with principles of FT-AN in conjunction with other complementary treatment modalities, all of which serve to mobilize parents to take action towards recovery, prepare families to manage recovery in the home, and facilitate rapid and sustained symptom remission within the patient. These objectives are achieved by employing therapeutic strategies that increase parental competency, facilitate a familial framework that supports recovery, and provide a structured plan that promotes consistency in parental approaches that promote recovery-focused behavior on the part of the patient.

Family Therapy

Systemic principles are applied in therapeutic activities through IFT, both in the multi-family group and in single-family sessions. Family therapy approaches are primarily borrowed from principles of FT-AN and multi-family therapy; however the model also borrows approaches that are rooted in broader systemic theory and application. FT-AN strategies such as the prioritization on weight and physical health, acknowledging and mobilizing parental anxiety, illness externalization, and a pragmatic focus are considered key systemic techniques in IFT, and are employed at the outset of treatment to facilitate parent mobilization.

IFT is modeled on multi-family therapy for eating disorders, where multiple families are treated simultaneously in a group format. The multi-family context is used to introduce and reinforce FT-AN techniques and the underlying philosophy of parents as the champions of recovery. Delivering key FT-AN strategies and approaches in a multi-family format is thought to enhance the uptake of these principles through the construction of group and parent-to-parent solidarity, as well as increased opportunities to learn and receive feedback from others through both observation and direct inter-family feedback (Murray et al., 2014). Broader multi-family therapy activities, such as inter-family role plays and cross-generational interviews amongst group members, are used to assist families in reflecting on structural family changes and systemic family patterns and alliances that will facilitate movement towards recovery.

Family Meals

IFT is unique in that it includes multiple family meals over the course of treatment. On a daily basis, families eat breakfast, lunch, and two snacks under therapist observation/supervision as part of the program, resulting in approximately 15–20 therapist-supported family meals. Mealtimes, particularly in the early stages of treatment, are an opportunity for therapists to assess key mealtime behaviors, both parent and adolescent, in order to formulate target intervention points to reduce eating disorder symptoms. Mealtimes are then used as an opportunity for in-vivo intervention, where parents are being led through the use of appropriate strategies to improve adolescent mealtime behavior. Similarly, therapists coach the adolescents on how to effectively use skills to increase compliance while also managing anxiety and other distressing emotions associated with mealtimes. Interventions with parents include direct feedback on the appropriateness of the meal (caloric sufficiency, quantities, and variety of food) and parent coaching on implementing behavioral strategies for maximizing the likelihood of eating and for managing negative affect and/or behavioral issues related to eating. Interventions directed at patients include teaching and modeling positive reinforcement, re-directing, distress tolerance skills, and other appropriate behavioral management strategies. In line with the FT-AN informed stance of therapists as consultants, the majority of therapist feedback is directed towards parents, with the ultimate goal of the therapist being to inform and assist parents in deciding on the appropriate ways to intervene. The parent focus is crucial, as it is ultimately the parents, and not therapists, who deliver the intervention in order to facilitate a successful transition to home-based treatment management.

Parent Skills Training

Throughout the program, parents receive didactic behavioral skills training in an effort to improve their effectiveness in managing eating disorder behaviors. Similar to FT-AN, the IFT model recognizes that parents' existing skill sets can be used to facilitate recovery, while also recognizing that adolescents' strong behavioral reactions to undergoing recovery can be difficult to manage. Although it is true that parents must capitalize on their previous experiences in successfully directing children to healthy behaviors and managing negative emotions, many parents feel unequipped to deal with such powerful reactions like those associated with eating disorders. Additionally, the intensity of reactions in patients with eating disorders may dissuade normally functioning parents from intervening. IFT provides training to parents using skills adapted from the Parent Management Training program (PMT; Kazdin, 1997). PMT is a comprehensive set of parent-directed treatment techniques that were originally developed to enhance motivation and compliance

in treatment-resistant youth. The program is based on basic behavioral principles and uses praise, reinforcement, and contingency management to achieve specified target behaviors. Parent training is both didactic and experiential in nature. Parents are taught behavioral management skills in parent-only sessions and coached through effective application of these skills in interactions with their adolescents.

Behavioral Contracting

A substantial portion of treatment provided during the week surrounds the goal of constructing a family behavioral contract. The behavioral contract is intended to be a document that guides families forward in recovery by outlining guidelines for mealtimes and eating behavior, weight recovery, and other cardinal factors on which recovery is based. The contract outlines a stepped behavioral program to reach target benchmarks (such as target weights) to ensure that families possess a roadmap that specifies behaviors that are necessary for achieving recovery. In addition to defining rules and expectations, the contract defines contingencies for each target behavior expected of adolescents. This establishes a parental protocol for responding to adolescent behavior to not only ensure parental consistency in their response sets, but also to promote recovery-oriented behavior on the part of the adolescent through the use of positive and negative contingencies. Thus, the contract serves as both a way to enhance adolescent compliance with key behaviors such as eating, and to promote consistent and effective management strategies on parents' behalf. Furthermore, the contract facilitates the construction of a strict and predictable structure surrounding recovery by insisting that families specify a detailed routine for things such as times of meals. This approach may be particularly well-suited for individuals with eating disorders who often display difficulty tolerating uncertainty and anticipatory anxiety and avoidance behaviors in response to novel situations (Hildebrandt, Bacow, Markella, & Loeb, 2012). Behavioral contracts are highly individualized and are structured to take into account specific family circumstances, recovery needs, patient motivating factors, caretaker leverage, and patients' sensitivity to reward and punishment. Upon discharge, each family leaves with a signed document constructed in collaboration with treating therapists.

Patient Skills Training

A segment of the IFT program is devoted to teaching patients adaptive coping skills to manage distress and challenging emotions that may arise during recovery. Contemporary neurobiological findings suggest that individuals with eating disorders experience emotion dysregulation that may

contribute to eating disorder behaviors such as restricting, bingeing, and purging (Kaye, Fudge, & Paulus, 2009; Kaye et al., 2013). Both food receipt and the anticipation of food receipt may cause extreme anxiety, which is thought to contribute to avoidance behaviors such as food restriction (Kaye et al., 2013). Patients are taught coping strategies, akin to those taught in dialectical behavior therapy (Linehan, 2015) to tolerate distress, and therapists facilitate opportunities for practice of these skills throughout the program, particularly surrounding mealtimes. The ability for therapists to be present at mealtimes and other times throughout the day where distress levels rise allows for therapist-directed skills practice on an as-needed basis, as patients acquire and master a “toolbox” of skills. While the majority of skills training occurs with patients only, one to two group sessions throughout the week are devoted to “family skills training,” in which skills are introduced to the entire group so that family members can utilize skills in managing their own distress while also modeling appropriate skills usage for the patients.

Psycho-Education

Throughout the week, families attend didactic and interactive lectures during which information pertinent to medical and biological aspects of eating disorders is covered. Psycho-education sessions are presented in an informal didactic style by university faculty with expertise in specific eating disorder-related areas and include medical consequences of eating disorders, physiological effects of starvation, temperament and personality contributors to eating disorders, neurobiology of eating disorders, and best medical practices for eating disorders. Additionally, the psycho-education sessions serve to strengthen the FT-AN guided objectives of mobilizing caretakers by creating urgency, reducing familial blame, and further empowering parents as critical treatment team members in their child’s recovery.

CONCLUSION

The IFT program represents a brief, intensive model of treatment for children and adolescents with eating disorders. The program focuses on delivering a comprehensive treatment that prepares families for engineering a successful recovery from their adolescents’ eating disorder by providing skills, education, and immersive practice based on a contemporary and updated understanding of these illnesses. The treatment represents an integrated treatment program that consists of both well-established evidence-based treatment and novel treatment techniques employed with a strong theoretical rationale, resulting in a robust model that promotes familial self-efficacy and improves families’ chances of succeeding with recovery in the home.

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