Family Based Treatment for Adolescent Eating Disorders

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Purpose of the Institute

- To disseminate evidence based treatments for child and adolescent eating disorders.
- To provide training to a set standard of specific skill sets.

The Institute provides several levels of training

- Basic Introduction to key intervention models
- Specific Training in key models
- Certification for treatment in key models
- Certification for supervision of treatment in key models
- Certification for training others in key models
- Consultation for services and program development
Current Institute Training

- Family-Based Treatment (FBT), also sometimes called the Maudsley Approach, for adolescent AN and BN
- Cognitive-Behavior Therapy (CBT) for adolescent BN
- Adolescent-Focused Therapy (AFT) for adolescent AN

Outline of Presentation

1. Hospitalization for AN and the Disempowerment of Parents
2. Overview of the Family-Based Treatment Model
3. Scientific Support for FBT for AN and BN
4. Fundamental Assumptions
5. FBT in Detail

Sir William Gull (1816-1890)

“The patients should be fed at regular intervals, and surrounded by persons who would have moral control over them; relatives and friends being generally the worst attendants.”

Jean Martin Charcot (1825-1893)

“It is necessary to separate both children and adults from their father and mother; whose influence, as experience teaches, is particularly pernicious.”

Hospitalization for Adolescent AN: Not Better than Outpatient Treatment According to Existing Studies

Crisp et al 1991

Gowers et al 2007
Overview of Family-Based Treatment

• Based on FT developed at the Maudsley Hospital in London in the 1980s
• Manualized FBT developed and systematically evaluated at UChicago (now UCSF) and Stanford University
• FBT utilizes key strategies or interventions from a variety of Schools of Family Therapy
  o Minuchin – Structural Family Therapy
  o Selvini-Palazzoli – Milan School
  o Haley – Strategic Family Therapy
  o White – Narrative Therapy
• Adapted for use with adolescents with BN by the Maudsley Group and manualized by Le Grange and Lock.

Suitability and Context

• Appropriate for children and adolescents who are medically stable
• Outpatient intervention designed to a) restore weight and/or decrease binge eating and purging; and b) put adolescent development back on track
• FBT is a team approach, i.e., primary therapist, pediatrician and child & adolescent psychiatrist
• Brief hospitalization sometimes used to resolve medical concerns

Three Phases of FBT

Phase 1
• Parents in charge of weight restoration or supporting decrease in binge eating or purging

Phase 2
• Parents hand control over eating back to the adolescent

Phase 3
• Discuss adolescent developmental issues
Treatment Style

Parents in charge
- Appropriate control
- Ultimately relinquished

Therapist stance
- Active – mobilize anxiety
- Deferece to parents

Adolescent Respect
- Developmental process
- Traditional treatment upside-down

Evidence supporting FBT for adolescent eating disorders

Russell et al (1987) AN (n=40)
Eisler et al (1997) follow-up
Le Grange et al (1992) pilot AN (n=16)
Eisler et al (2000) AN (n=40)
Eisler et al (2007) follow-up
Robin et al (1999) AN (n=36)
Lock et al (2005) AN (n=86)
Lock et al (2006) follow-up
Le Grange et al (2008) BN (n=80)
Schmidt et al (2008) BN (n=80)
Lock et al (2010) AN (n=121)
Le Grange et al (2014) follow-up
Agras et al (2014) AN (n=164)
Madden et al (2014) AN (n=80)
Le Grange et al (2015) BN (n=136)
Le Grange et al (2016) AN (n=107)

Summary: Evidence base for FBT for Adolescent AN and BN

Total participants=986 (690 AN/296=BN)
Total # of Studies= 11 (9AN/3BN)
Total sites: 12 different sites in 4 countries
9 single site/3multi-site studies
4 Follow-up studies
1 Meta-analysis (Couturier et al., 2013)

FBT is superior to non-specific individual therapy for adolescent AN

“Excessive concern with the body and its size, and the rigid control over eating, are late symptoms in the development of youngsters who have been engaged in a desperate fight against feeling enslaved and exploited, not competent to lead a life of their own.”

“...are late symptoms in the development of youngsters who have been engaged in a desperate fight against feeling enslaved and exploited, not competent to lead a life of their own.”

The avoidant position in anorexia nervosa is therefore a profoundly psychosomatic one, rooted in the seemingly miraculous and certainly unique capacity to reverse pubertal process and hence all of its social and psychological impacts.

Developmentally specific individual therapy for adolescent AN is not superior to FBT

Remission Rates (normal weight and EDE) Favor FBT over AFT (specific individual tx)

Other findings

- FBT and AFT similarly acceptable: Dropout, though low in both treatments, no differences between the two groups.

- FBT works faster: By 3 months 38% (N = 23) of FBT participants had reached 95% IBW vs 20% (N = 12) in AFT F(1,105)=5.5 p=.021

- Hospitalization greater in AFT: Significantly more participants were hospitalized in AFT (n=32; 37%) compared to FBT (n=9; 15%), p.05 during treatment.
Moderators of Outcome in FBT and AFT: More severely ill patients did better in FBT

- Le Grange et al. 2012

- Therapeutic alliances were strong for both adolescents and parents throughout treatment (Pereira et al, 2006; Forsberg et al 2013)
- Early patient therapeutic alliance (bond) predicted early weight gain (Pereira et al, 2006)
- Early parental therapeutic alliance predicted staying in treatment (Pereira et al, 2006)
- Early weight gain predicted end of treatment EDE scores and therapeutic alliance (Pereira et al, 2006)
- Therapeutic alliance better in AFT than FBT, but no effect on outcome (Forsberg et al 2013)

The Effects of FBT are not due to Therapeutic Alliance alone

- 7 site study: FBT to SFT (N=164)
- No differences in outcomes between groups on weight change.
- FBT leads to quicker weight restoration (F(1,146) = 8.8, p=.003), 8.3 days for FBT and 21.0 days for SFT.
- FBT used fewer hospital days (8.3 days for FBT and 21.0 days for SFT), and lower treatment costs ($8,963 for FBT vs $18,005 for SFT).
- The average costs per individual recovered were $21,947 for FBT and $46,465 for SFT.
- Moderator: For patients with elevated CYBOC scores, SFT was more effective.

FBT lowers costs and hospitalization use compared to SFT

- Need for Hospitalization is reduced when followed by FBT

Compared short term weight stabilization (WS) only to weight restoration (WR) (N=82). At the end of hospitalization all received FBT.

At the end of the baseline hospitalization those randomized to WS used 15 days compared to 37 in the WR group. This was a significant difference. This was the only difference in outcome in the study at any time point.

At follow-up no difference in remission rates or rehospitalization rates.

Moderators: Those with OCD symptoms did better in the WS group.

Madden et al., 2015
Dissemination Effects on Reducing Need for Hospitalization

- FBT was implemented in 2004 at Westmead Children’s Hospital, Sydney (Wallis et al., 2007):
  - 50% decrease in readmissions over the implementation period
- FBT was implemented in 2009 at RCH in Melbourne (Hughes et al., 2013):
  - 56% decrease in admissions,
  - 75% decrease in readmissions,
  - 51% decrease in overall hospital days

Separated FBT (Parent Focused Therapy-PFT) leads to faster remission weight gain (>94%mBMI) in less severely ill patients

- FBT vs PFT Study
  - N=107 adolescent AN
  - FBT n=55
  - PFT n=52
  - 6- and 12-mo F/U
  - PFT had greater remission rates at 6 mos. (EOT) but not at follow-ups
  - No differences in mBMI% at any time point
  - No difference in EDE at any time point
  - Moderator: Those with greater severity of OCD ED (YBC-ED scores symptoms do better in FBT

Guided Parental Self-Help FBT (GSH-FBT) may improve access with similar outcomes as FBT

Parents trained using internet delivered videos and support
Guided for 20 minutes per week for 12 sessions for 12 weeks (n=19)

Early weight gain predicts long term outcome in FBT

- Weight gain >4 lbs. by wk 4 correctly characterized:
  - 79% of responders [AUC = .814 (p<.001)]
  - 71% of non-responders [AUC = .811 (p<.001)]
Intensive Parental Coaching (IPC) improves response for early non-responders

For those who do not respond (i.e., gained 2.3kg) to FBT IPC was offered at session 4. IPC is 3 additional sessions devoted to helping parents be more effective at re-feeding.

HOW? Parents vs AN scores at session 2 of FBT. Mothers whose children respond earlier believe they are more self-efficacious at re-feeding.

Post IPC: Parents vs AN scores improved in the non-responder group. No difference in self-efficacy between early responders and those who did not after IPC.

FBT is effective in a 6 month/10 session dose

- 86 adolescents with AN were randomized to 20 sessions/12 mos. Vs 10 session/6 mos. of FBT.
- No difference in outcome at any time point.
- Moderators: Those with more severe ED related obsessions or from non-intact families did better.

FBT superior to CBT for Adolescent BN

This two-site RCT 130 participants (aged 12-18 years) meeting DSM IVth Edition criteria for BN or partial BN (binge eating and purging once per week for six months).

Treatments were comprised of 18 outpatient sessions over 6 months. Participants in FBT-BN achieved higher abstinence rates than in CBT-A at EOT (39% vs. 20%; p=.040, NNT=5) and at 6-month follow-up (44% vs. 25%; p=.030, NNT=5). Abstinence rates between these two groups did not differ statistically at 12-month follow-up (49% vs. 32%; p=.130, NNT=6).

CBT remission rate similar to that in adult BN studies.
Rates of Psychiatric Co-Morbidity are high in EDs

Summary of Co-morbidity in Treatment Trials

Depression in adolescent AN to range from 17-35%, with a mean rate of 17%;
Anxiety disorders in AN excluding OCD ranged from 7-35%, with a mean rate of 9%;
OCD rates in AN ranged from 4-14%, with a mean rate of 4%;
PTSD rates in AN ranged from 2-17%, with a mean rate of 3%;
Other diagnoses (e.g., ADHD, phobias, Tics, Substance abuse) ranged from 5-7%, with a mean rate of 5%.
The overall co-morbidity rate in AN was 37% (181/485)
For adolescent BN we find a mean overall co-morbidity rate of 59% (162/274), with a range of 48-67%, with depression being the most common co-morbid diagnosis.

Co-Morbid conditions in Adolescent BN respond to ED treatments and may not require separate care

In a post hoc examination of the CBT vs FBT, there were large and significant improvements in self-esteem and depression regardless of treatment type

Other related studies for other ED populations

Data support use of FBT for AN under 12 (Forsberg et al., 2009)
Adaptations available for ARFID (Fitzpatrick et al., 2014)
Adaptations available for young adults FBT-TAY (Dimitropolous et al., 2014)
Upcoming and Proposed Studies

1. Cognitive Remediation Therapy plus FBT vs Art Therapy plus FBT
2. Using the internet to train and improve therapists' fidelity to FBT
3. FBT for ARFID
4. Parent Focused Therapy for mother with EDs
5. FBT-TAY for young adults with AN
6. GSH-FBT vs FBT for adolescent AN
7. Adaptive Treatment for adolescent AN

Fundamental Assumptions

1. Agnostic view of cause of illness
   Neither parents nor adolescent are to blame
2. Non authoritarian therapeutic stance
   Joining with family
3. Parents are responsible for weight restoration
   Empowerment
4. Externalization
   Separation of child and illness
5. Initial focus on symptoms
   Pragmatic

3. Fundamental Assumptions Underlying Family-Based Treatment

1. Agnostic View

   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 (etiology is not the focus of treatment)
Strategies to Maintaining Agnosticism

- Do not pathologize
- Practice forgetting what you think you know
- Do not theorize - work with what’s in front of you
- Work with and encourage strengths, not weaknesses
- Use supervision to identify problems in maintaining perspective
- Intervene with serious pathology (abuse, neglect) supportively and immediately

Practice Forgetting What You Think You Know

- I do not consider it an insult, but rather a compliment to be called an agnostic. I do not pretend to know where many ignorant men are sure -- that is all that agnosticism means.” - Clarence Darrow
- “Extraordinary claims require extraordinary evidence.” - Carl Sagan
- “In all affairs it’s a healthy thing now and then to hang a question mark on the things you have long taken for granted.” - Bertrand Russell
- “If you see a man approaching you with the obvious intent of doing you good, you should run for your life.” - Henry David Thoreau

2. Therapeutic Stance

- Therapist serves as expert consultant
- Therapist is active in treatment
- Therapist does not control parents or patient
- Most decisions are left to parents
- This consultative stance supports therapeutic autonomy for parents

Being a good consultant

- Know the medical and psychological literature on ED
- Know how adolescents with EDs “think”
- Set specific goals about changing eating and weight loss behaviors with family
- Involve the entire family
- Help family anticipate process (i curve)
- Don’t overwhelm with information
- Remember families will want you to tell them what to do and when you do they will fail and blame you
- Join the family in solving problems
3. Parental Empowerment

- The family is a resource for helping the patient
- Most families can help their child
- The family has skills to bring to the treatment
- The therapist leverages parental skills and relationships to bring about change

Strategies for Empowerment

- Listening and asking, not telling
- Suggestions, not orders
- Advice, not prescriptions
- Information, not instructions
- Support and positive feedback, not criticism
- Use examples

4. Separation of illness from adolescent ("Externalization")

- The adolescent and parent are not to blame
- No pathologizing of patient (not regressed, immature, or seeking attention, but ill)
- Respect adolescent without negotiating with ED
- Supports increased autonomy with recovery from ED

Strategies for Externalization

- Disease model (cancer)
- Possession model (alien)
- Intellectual model (Venn diagram, eclipse)
5. Initial Symptom Focus

- Emphasis is first on behavioral change
- History-taking focuses on symptom development
- Delay of other issues until patient is less behaviorally and psychologically involved with ED
- No direct focus on cognitive symptoms of the ED

Strategies for Remaining Focused

- Use weight chart
- Avoid “other issues” e.g. etiology, causation
- Initial strategy is to limit medical impact of ED
- Keep tasks of session in mind – i.e., follow the manual

Effects of FBT Tenets?

- Highly focused, staged treatment
- Emphasis on behavioral recovery rather than insight and understanding or cognitive change
- This approach might indirectly improve family functioning and reduce eating related cognitive distortions for the adolescent

Treatment Process
Treatment Process Illustration: A long steady climb

Treatment Process Illustration: Food is the Best Medicine

Treatment Process Illustration: Setting Expectations

3. Setting up Treatment
Core Eating Disorder Evaluation

- Interview with the adolescent
- EDE + PEDE (Structured Eating Disorder Assessment)
- K-SADS or MiniKid
- Other paper-and-pencil tests
- Interview with the parents
- Medical evaluation and plan for outpatient treatment

Setting up Treatment

Therapist Call to family
- Key words are ‘crisis’ & ‘same page’
- Establish that there is a crisis in the family
- Explain the context of treatment, i.e., the treatment team and the family and the importance of being on the same page
- Begin process of enhancing parents’ authority to manage this crisis
- Reinforce the necessity of all family members attending the sessions
- Discuss confidentiality issues: For the patient—eating related discussions are not confidential, but other personal issues are except those mandated to be reported. For the parents—eating related discussion outside the sessions are not confidential, but other personal issues are except those mandated to be reported.

The Team

FBT is a team approach

Primary therapist (FBT)
(Responsible for FBT and coordinating care)

Pediatrician/Adolescent Medicine
(Responsible for the medical safety of patient)

Child/Adolescent Psychiatrist
(Manages any psychiatric disorder)

Expertise required to Practice FBT

Mental Health Professional (Therapist)
- Child and Adolescent Psychiatrist
- Psychologist
- Social Worker
- Nurse Therapist

Experience working with adolescents and families

Eating disorder expertise
Changing Roles of Team Members

- Lead therapist (psychologist/psychiatrist/social work therapist)

- Psychiatrist

- Adolescent Medicine/Pediatrics

- Nutritionist

4. Common Dilemmas

- 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

- Scared Parents
Fitting Patients to Treatment

Single-Parent Households
• Therapist is important resource
• Find additional adult ally (e.g., grandparent)
• Treatment might take longer
• Child parentified

Single-Child Families
• 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 an eye on the ball

Phase 1: Weight Restoration or Disruption of Binge Eating or Purging
Overview of Phase 1

- Focus is on helping parents take control of weight restoration processes
- Lasts between 8-10 sessions, usually weekly
- Designed to help parents do at home what nurses would do on an inpatient unit
- Principle aim is to help parents disrupt severe dieting, exercise, and related dysfunctional behaviors that are leading to/maintaining low weight

Session One

Goals:
- Engage the family
- Obtain a history of how ED affects family
- Assess family functioning (coalitions, conflicts)
- Reduce parental blame

Interventions include:
- Greeting family in sincere but grave manner
- Using circular questioning to obtain history
- Separating illness from patient
- Orchestrating intense scene concerning ED
- Charging parents with the task of weight restoration
- Summary of session, instructions for family meal

Goal: Engaging the Family

- Families are often too anxious or not anxious enough - need to get them in the therapeutic window to accept the possibility of change
- Need to create a type of therapeutic bind - warm but worried and firm

Goal: Take a Focused History with the Family

- Use the history taking process to engage all family members in developing a shared narrative of how ED developed and is changing the family
- The therapist must keep the history taking highly focused
Goal: Assess Family Functioning

- Purpose is NOT to identify family problems in a general sense
- Identify specific problems that the family might have that interfere with their ability to work together to achieve weight restoration

- Common problems include: parents not aligned, one parent over-identified with or anxious about the patient, disengaged parent, conflicts between parents, conflicts between siblings
- These exist in all families; particularly under conditions of stress and do not cause illness, but can help maintain patterns of illness behaviors

Goal: Reduce Parental Blame

- Purpose is to help increase parental confidence in their ability to help their child
- Guilt reduces self-efficacy
- Guilt should be confronted directly, as many parents feel guilty if their child becomes ill for any reason, but particularly with psychological illnesses, and even more particularly, eating disorders
- Parents may also feel guilt throughout renourishment and behavior change process if they feel they are not "helping enough"
- This guilt interferes with problem-solving

Intervention 1: Greeting the Family

- Make eye contact with each family member
- Ask each family member a bit about themselves (interests, grade, work)
- Briefly orient the family to the phases of treatment, particularly the first phase
- Manner is serious while welcoming

Intervention 2: Circular Questioning for History of ED

- Open the session by asking the family as a whole about the onset and course of the ED
- Ask another family member for confirmation, elaboration, or editing of previous comment
- Make sure all family members contribute
Intervention 3: Separating the Illness from the Patient

- Purpose is to free parents to take definitive action to disrupt weight loss and other ED related behaviors as well promote weight gain when needed
- There is sometimes protest from the patient, but use the history to provide evidence that there was a time when things were different
- "driving under the influence of ED"

Intervention 4: Orchestrate an Intense Scene

- Purpose is to summarize the information gathered about how ED developed and combine it with the facts about the seriousness of ED to raise the anxiety of family members about the need to take action
- Include information about mortality, morbidity, long term outcome, value of early intervention, effectiveness of parents

Intervention 5: Charging Parents with Task of Weight Restoration

- Purpose is to bring the need for action to a head by telling the parents that they are the best resource for helping their child
- This should be delivered warmly, with assurances of assistance from the therapist, but also firmly and with confidence that, with effort, they will succeed

Intervention 6: Summary and Instructions for the Family Meal

- Purpose is to highlight the main learning from the session and to anticipate the next session
- Brief in duration and sharp in focus
- Instructions for family meal
- Ask parents to bring a meal that the two of them decide will help their child gain weight
- "Bring a meal that will help renourish your starving child" for AN or one that includes a triggering food for BN.
How is FBT different for BN?

- Treatment is more collaborative
- Emphasis on regulating food intake, and curtailing binge/purge behavior
- Family meal in BN
  - Help adolescent eat regular meal
  - Includes food that typically trigger binge
  - Explore adolescent’s feelings around urges to binge and purge

Specific Challenges in FBT for BN

- Developmental stage of BN adolescents
- Secretiveness (shame and guilt) of BN
- Bulimic symptoms can elicit criticism
- Comorbidity and BN
- Heterogeneity of BN
  - Family status/SES
  - Cultural background

Session Two: The Meal

Major Goals of Session:

- Assess family structure as it may affect ability of parents to restore the adolescent’s weight
- Provide opportunity for parents to succeed in convincing adolescent to eat more than intended
- Assess family process during eating
Session Two: The Meal

Interventions in Session:

- Weighing the patient and ask about eating, exercise, binging eating and purging
- Taking a history, observing family patterns around eating, learn about food preparation, food serving, and discussions around meal times
- One more bite
- Aligning patient with siblings for support

Session Two for BN

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<th>Goals:</th>
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<tr>
<td>Assess family structure as it may affect ability of parents and adolescent to work together</td>
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<td>Provide opportunity for parents to successfully persuade adolescent to eat trigger food</td>
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Remainder of Phase 1
Remainder of Phase 1: Sessions 3-10

Goals:

- Keep the family focused on the ED
- Help the parents take charge of child’s eating
- Mobilize sibling support for patient

Remainder of Phase I: (Sessions 3-10)

Interventions Include:

- Weighing the pt at start of each session and discussion of any problems the patient wants to have.
- Directing, redirecting, and focusing the discussion on food and eating
- Supporting parental dyad, modifying criticism toward pt, externalizing illness
- Helping family to evaluate efforts of siblings to support their sibling

Issues specific to Phase I

- Balance between meeting adolescent on her own and meeting family as a whole
- Weighing the patient and how to manage the number with the adolescent
- Sharing the weight chart with family with weight setting the tone of the meetings
- Working out with the parents how they can help their adolescent restore weight
- Helping the family to get their ‘ducks in a row’ (facilitating parental learning)
- It’s OK to be a little pedantic!

By the end of Phase 1…
Phase II AN (Sessions 11-16): Help Adolescent Eat Independently

Guidelines for transition to Phase II:

- Weight is usually at a minimum of ~90% IBW
- Patient eats without significant struggle under parental supervision
- Parents report they feel empowered to manage illness

Phase II

Goals:

- Maintain parental management until pt can gain weight independently
- Transfer food/weight control to adolescent
- Encourage the adolescent to engage in normal adol activities that involve peers, eating and exercise

Interventions Include:

- Weigh patient at every session
- Assist parents in managing the ED and in navigating return of control of eating
- Continue to assist siblings in supporting their sister
- Continue to highlight differences between adolescent's own needs and those of AN
- Closing sessions with positive support
Phase II BN (Sessions 11-16)
Support Adolescent’s Independence

- Guidelines for transition to Phase II:
  - Blood pressure symptoms reduced >80% and weight is stable
  - Adolescent eat in healthy ways without significant struggle
  - Parents demonstrate their empowerment to help adolescent manage illness

Remainder of Phase I for BN (Sessions 3-10)

- Goals:
  - Keep parents and adolescent focused on BN
  - Support collaborative efforts of parents and adolescent

- Interventions Include:
  - Start of each session, weigh pt, collect b/p report and inquire if s/he needs help raising issues
  - Continue focus on eating, modification of criticism toward pt, externalization of illness

Phase III: Tracking Back to Normal Adolescent Development

Assessing Readiness: • Symptoms have dissipated (weight > 90% IBW), but some shape and weight concerns may remain

Goals:
  - Revise parent-child relationship in accordance with remission of AN
  - Review and problem-solve re. adolescent development
  - Terminate treatment
Phase III

Interventions include:
• Review normal adolescent development; establish that patient is back on normal trajectory in all domains
• Model problem-solving behavior
• Check parents relationship as a couple
• Discuss fear of relapse; plan
• Terminate

Review Adolescent Development

• Puberty and body adjustment (ages 11-13)
• Social identity and roles (ages 14-16)
• Intimacy and leaving home (ages 17-18)

Getting Started

• Interview parents about each stage
• Changes focus from the adolescent
• Creates empathic “memory” in parents about dilemmas of adolescence
• Normalizes adolescent experience
• Psychoeducation

Identifying Key Adolescent Issues

• Create dialogue between parents and adolescent about adolescent issues they’re facing (depends on age of patient)
• Sex
• Drugs
• Friends
• Rules
Brief Work on Key Issue

- Assign/ask parents and adolescent to pick a key issue and work out how they want to solve it
- Provides analogue for parents and child to solve adolescent dilemmas
- Not meant to be general adolescent therapy
- Identify issues that need further work beyond FBT

Termination

Termination starts with Session 1
- Empowering family from outset makes termination less of an issue
- Decreasing frequency of sessions over the course of treatment makes termination less of an issue
- Identify current status (revisit Venn diagram)
- Referral for additional treatment for other problems, if necessary

Phase III BN (Sessions 17-20) Adolescent Issues

- Assessing Readiness:
  - Symptoms have dissipated (almost no b/p), although some shape and weight concerns may remain
- Goals:
  - Revise parent-child relationship in accordance with remission of BN
  - Review and problem-solve re adolescent development
  - Terminate treatment

Phase III BN

- Interventions Include:
  - Review normal adolescent development; establish that pt is back on normal trajectory in all domains
  - Model problem-solving behavior
  - Check parents relationship as a couple
  - Encourage fear of relapse; plan
  - Terminate