Anorexie Mentale et Thérapies Multifamiliales: l’Approche MAUDSLEY

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A bit of history
Sir William Gull (1873)

“The treatment required is obviously that which is fitted for persons of unsound mind. The patients should be fed at regular intervals, and surrounded by persons who would have moral control over them; relations and friends generally being the worst attendants”

Charles Lasegue (1873)

Described *anorexia hysterique* as intimately connected to the dynamics and conflicts in the patient’s family and recommended separating her from the family.
1970s

Family dynamics as an explanatory model of anorexia nervosa
Emphasized role of mother infant relationships in which the mother’s strong need to look after the child leads her to anticipate the child’s needs and to attempt to meet these needs before the infant can experience them herself.

Because of this the child never fully develops an interoceptive awareness of her needs, giving her a sense of over-dependence and of pervasive ineffectiveness.

With the onset of adolescence this leads to a lack of sense of identity and a need for control for which anorexia become the “solution”.

THE PSYCHOSOMATIC FAMILY

“First, the child is physiologically vulnerable, ....

Second, the child’s family has four transactional characteristics:

• enmeshment
• overprotectiveness
• rigidity
• lack of conflict resolution.

Third, the sick child plays an important role in the family’s pattern of conflict avoidance; and this role is an important source of reinforcement for his symptoms.”

1980s

From treating *the* family
to
treating *with* the family
The old epistemology implies that the system creates the problem. 

The new epistemology implies that the problem creates the system.

The problem is whatever the original distress consisted of plus whatever the distress on its merry way through the world has managed to stick to itself.


1980s

Emerging evidence of the effectiveness of family therapy
Open follow-up studies of family therapy in adolescent anorexia nervosa


Family therapy and individual therapy following inpatient treatment

**Family therapy**

- **EOT**: 75% Good, 25% Intermediate, 0% Poor
- **5yFU**: 50% Good, 50% Poor

**Individual therapy**

- **EOT**: 50% Good, 50% Poor
- **5yFU**: 25% Good, 75% Poor

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1990s

Narrative, social constructionist and constructivist developments
1990s

Growing evidence of the effectiveness of family therapy

+ Lack of evidence for a family explanatory model of anorexia
Growing evidence of the efficacy of family therapy for adolescent AN


2000s

Move towards integration of psychotherapies (including multi-family therapy)


2000s
Consolidation of empirical evidence supporting FT
Consolidation of empirical evidence supporting the efficacy of family therapy


Godart et al (2012) A randomized controlled trial of adjunctive family therapy and treatment as usual following inpatient treatment for AN adolescents, *PLoS ONE*, 7 art. no. e28249,
Family Therapy vs Adolescent Focused Individual Therapy (Lock et al 2010)

Family therapy

<table>
<thead>
<tr>
<th>EOT</th>
<th>6 m FU</th>
<th>1 y FU</th>
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<td>Remitted</td>
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Individual therapy

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Lock, Grange et al 2010 Randomized Clinical Trial Comparing Family-Based Treatment With Adolescent-Focused Individual Therapy for Adolescents With Anorexia Nervosa. Archives of General Psychiatry, 67, 1025-32
Summary findings from adolescent anorexia nervosa family therapy studies

• By end of treatment 65-90% reach a healthy weight
• At long term follow-up 75-90% are well
• Best individual therapies are effective in 65% cases
• Differences between family therapy and individual therapy continue for up to 5 years
• Relapse rates following successful FT are generally low (< 10%)
How effective is multi family therapy
Multi Centre Treatment of Adolescent Anorexia Nervosa (McTaan study)
<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
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<tr>
<td>Aged 13 – 20</td>
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<tr>
<td>W4H below 86% (equivalent to 10\textsuperscript{th} BMI percentile) or</td>
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<tr>
<td>Rapid weight loss of 15% or more in last 3 months</td>
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<tr>
<td>DSM-IV AN or EDNOS (restrictive) diagnosis</td>
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<tr>
<td>Exclusion Criteria</td>
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<td>--------------------------------------------------------</td>
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<tr>
<td>In care</td>
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<tr>
<td>Learning Disabilities</td>
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<tr>
<td>Psychosis</td>
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<tr>
<td>Alcohol / substance dependence</td>
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<tr>
<td>Co-existing medical condition e.g. diabetes</td>
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<tr>
<td>W4H &lt; 67%</td>
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<tr>
<td>or</td>
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<tr>
<td>W4H 67-70% + one or more of</td>
</tr>
<tr>
<td>dehydration</td>
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<tr>
<td>bradycardia (pulse &lt;40 BPM)</td>
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<tr>
<td>Temperature below 34.5°</td>
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<td>Electrolyte imbalance</td>
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</table>
Study sample

- N = 167
- Age \( \bar{x} = 15.9 \)
- Age of onset (years) \( \bar{x} = 14.7 \)
- Duration of illness (months) \( \bar{x} = 9.2 \)
- Sex \( \hat{\mathcal{F}} = 152 \quad \hat{\mathcal{M}} = 15 \)
- Weight (%W4H) at assessment \( \bar{x} = 78\% \)
Changes in weight during treatment and FU

**Assessment**
- Single family therapy: 72%
- Multi-family therapy: 74%

**3 months**
- Single family therapy: 76%
- Multi-family therapy: 78%

**12 months**
- Single family therapy: 80%
- Multi-family therapy: 82%

**6 month FU**
- Single family therapy: 84%
- Multi-family therapy: 86%

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Time x treatment: $F(3, 288)=2.94, p=.03$
Single Family Therapy vs Multi Family Therapy

Single family therapy

- 3 mths: >95%
- 12 mths: 85-95%
- 6 mth FU: <85%

Multi-family therapy

- 3 mths: >95%
- 12 mths: 85-95%
- 6 mth FU: <85%
What is the impact of the service context on treatment
Child and adolescent ED care pathways in London by PCT

- Royal Free Hospital
- Maudsley Hospital

- Refer to Specialist ED
- Specialist ED CAMHS
- Generic CAMHS
London care pathways study

- All services across London beyond primary care approached (NHS as well as private)
- Services asked to identify ED cases for 2007/08 aged 13-17 years
- Total of 42 services took part
- 27 CAMHS services took part (4 refused or agreed but failed to provide data)
- 479 cases identified of whom 378 met inclusion criteria
Aims of study

• Assess the impact of availability of specialist outpatient ED services on:
  – Rates of case identification
  – Rates of inpatient admissions
  – Clinical outcome
  – Health economic costs
Observed Incidence of AN per 100,000 females aged 13-17 years (London CPS)

F = 7.42; p < 0.004
Estimated incidence of BN per 100,000 females aged 13-17 years (London CPS)

$F = 6.57; \ p < 0.006$
Actual Care Pathways in London

Data obtained for 27/31 Primary Care Trusts

Detailed data based on 90 cases who gave consent for their case files to be reviewed
Outpatient and inpatient treatment in different settings (by care pathway)

Regression $p < 0.05$ odds ratio 3.6
Changes in care pathways in different treatment settings

- Specialist OP ED
- "Specialist ED" CAMHS
- Generic CAMHS

- Treatment in original CP
- Treatment in multiple CP
Conclusions: evidence based treatments or evidence based services?

- Specialist outpatient CAED services identify two or more times as many ED cases as generic CAMHS.
- Specialist CAED are able to significantly reduce the need for admissions to hospital.
- In specialist CAED 80-90% receive continuous care.
- In generic CAMHS 80% continuing care is rare (20% of those assessed; 40% of those who are offered treatment).
Conclusions

• Family therapy is an effective treatment for adolescent AN
• Multi-family therapy improves outcomes
• The most effective way of disseminating effective treatment is through community based specialist multi-disciplinary services
• Future treatment developments require
  – Revisiting of the theoretical tenets of family therapy
  – Research on the service context of treatment delivery
  – Research understanding of how treatment works
Frameworks for change
Frameworks for change

- Problem framework and a systemic formulation
- Relationship framework
- Maintenance framework
- Meaning creating framework
- Influencing framework
Problem framework and systemic formulation

- Broadening the frame
- Introducing a relational aspect
- Assessing risk
- Addressing feelings of guilt and blame
- Developing a systemic formulation
Developing a systemic formulation

- The nature of the problems that the young person and the family are struggling with
- Problem narratives, beliefs and cognitions
- Emotions and feelings that may be connected to the problem
- Mapping significant patterns
- Strengths, resources and resilience factors
- Motivation
Relationship framework

• Therapeutic alliance
• Transference/countertransference
• Use of self
Maintenance framework

• Maintenance vs. aetiology
• Evolution of maintenance patterns
• Maintenance patterns in the here-and now
Meaning creating framework

- Exploring individual beliefs and cognitions
- Exploring alternative meanings
- Exploring shared beliefs
- Exploring weak or unspoken stories
- Culture, gender, ethnicity, social class, family history
Influencing framework

• Collaborative relationships, professional expertise and power

• Choosing and sequencing interventions

• Self-reflexivity
Eating Disorders Focussed Family Therapy for Adolescent Anorexia Nervosa

Phase 1: Engagement and development of the therapeutic contract

Phase 2: Helping the family to challenge the symptom

Phase 3: Exploring issues of individual and family development

Phase 4: Ending and discussion of future plans
Phase 1: Engagement and development of the therapeutic contract

i. Developing a therapeutic alliance with the family and “reluctant adolescent”

ii. Problem focussed orientation

iii. Assessment of medical risk as part of creating a secure base for treatment

iv. Intensifying anxiety as a way of mobilizing family resources

v. Family perceptions of the problem and its development and exploring the effect of anorexia on the family

vi. Externalisation

vii. Giving information and owning expertise in ED

viii. Exploring the strengths and resources in the family

ix. Addressing feelings of guilt and blame
Phase 2: Helping the family to challenge the symptom

i. Exploration of what happens at mealtimes
ii. Challenging beliefs about the impossibility of parental action
iii. Offering options and discussion of ‘extreme’ possibilities
iv. Exploring parental roles
v. Therapeutic family meals
vi. Exploring the role that AN has acquired in the management of emotions, feelings and interpersonal relationships
vii. Exploration of motivation to change (discussing the effects of starvation; control of eating versus control over life; the advantages and disadvantages of change
viii. Broadening the time frame
Phase 3: Exploring issues of individual and family development

i. Exploring issues of growing up, adolescent independence, adolescent identity and self-esteem

ii. Exploring adolescent and parental uncertainty

iii. Exploration of family background, family values and cultural context of the family

iv. Taking responsibility for one's own behaviour and own emotions

v. Differentiating between ‘adolescent’ and ‘anorexic’ behaviour

vi. Exploring parental needs and the post-parenting phase of family life
Phase 4: Ending and discussion of future plans

i. Ending issues

ii. Remaining symptoms

iii. Relapse prevention

iv. Reviewing illness and recovery narratives
Individual sessions, individual therapy, separate individual and parent sessions

i. Confidentiality

ii. Motivation to change

iii. Peer relationships, interests outside the family

iv. Sexuality

v. Abusive experiences

vi. Hostility and criticism in the family

vii. Addressing co-morbidity
Connecting families with families
Family Therapy for Adolescent AN
General principles

- Treatment with the family vs treatment of the family
- Identifying strengths and mobilization of family as a resource
- Central focus on helping family to find solutions
- The role of information giving
- Expert vs non-expert positions
Family Therapy for Adolescent AN
General principles

- Challenging disabling family beliefs, perceptions and meanings (e.g. beliefs about guilt and blame)

- Blocking the central role of the symptom in the family organization

- Reinforcing of the family adaptation processes that enable developmentally appropriate family life-cycle changes
Principles of intensive MFT

- Overall conceptual approach same as single eating disorders focused family therapy

Additional principles
- Bringing together families with shared experiences
- Overcoming isolation and sense of stigmatization
- Creating new and multiple perspectives through which families can learn from one another
Other benefits of intensive MFT

- Creating “hot house” learning environment in which it is safe to practice new behaviours
- Offering expertise in the context of a highly collaborative therapeutic relationship
- Rediscovering family strengths and resilience to enable parents to take a central role in tackling their daughter’s eating problems
- To address problematic family interactions and communications, that have developed around the eating problems
Phases of treatment

Phase 1: Engagement and development of the therapeutic contract

Phase 2: Helping the family to challenge the symptom

Phase 3: Exploring issues of individual and family development

Phase 4: Ending and discussion of future plans
Intensive MFG programme for adolescent anorexia nervosa

- Initial assessment of the patient and the family
- Introductory evening
- Four day intensive programme (9.00 - 17.00)
- 5 – 7 one day follow-up meetings over 12 months
- Individual family therapy sessions between meetings depending on need
- Follow-up of individual and family as needed
Introductory evening

- Welcome
- Staff introductions
- Description of aims and structure of 4 day programme
- Psycho-educational talk on the effects of a starvation
- In smaller groups get families to introduce themselves to each other and meet families from previous groups.
- Q&A
Tuesday

9.30 - 10.30 Multi family introduction [interactional – e.g get families to introduce one of the families who they met at the Introductory evening.

10.30 - 11.00 **Morning Snack:**

11.00 - 12.30 **Parents:** lunch that day planning

**Adolescents:** ‘Portraying anorexia’ (draw, model or write something that symbolizes anorexia for you/your family)

12.30 - 2.00 **Multi Family Lunch**

2.00 - 3.30 Extensive feed back of all families to each other (Staff facilitate sharing and support)

3.30 - 4.00 **Afternoon Snack:**

4.00 - 5.00 **Whole group:** Reflections on the ‘portrayals of anorexia’
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>9.30 - 10.30</td>
<td>Feedback with a member from another family (chosen at random or pair an adolescent with an adult from another family) (with whole group first visualise one thing that went well, one thing that did not go well; what did you do, what did others do, what would you have wanted others to do etc)</td>
</tr>
<tr>
<td>10.30 - 11.00</td>
<td><strong>Morning Snack:</strong></td>
</tr>
<tr>
<td>11.00 - 12.30</td>
<td><strong>Whole group:</strong> Family sculpts</td>
</tr>
<tr>
<td>12.30 - 2.00</td>
<td><strong>Multi Family Lunch with “reconstituted” families</strong></td>
</tr>
<tr>
<td>2.00 - 3.00</td>
<td>Feedback about lunch using one-way screen</td>
</tr>
<tr>
<td>3.00 – 3.30</td>
<td><strong>Afternoon Snack:</strong></td>
</tr>
<tr>
<td>3.30 – 4.30</td>
<td><strong>Whole group:</strong> Traps and treasures</td>
</tr>
<tr>
<td>4.30 - 5.00</td>
<td>Reflections on the day, relaxation, visualization</td>
</tr>
</tbody>
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Thursday

9.30 - 10.30  **Individual Families**: Time line – how might things look in the year ahead.

10.30 - 11.00  **Morning Snack**:

11.00 - 12.30  Joint discussion of time charts

12.30 - 2.00  **Multi-family Lunch**

2.00 - 2.45  **Adolescents**: using paper plates and pictures from food magazines prepare meal for a Sunday lunch for their parents.

  **Parents**: What have you learned about yourselves, about your own resources, you as a couple

2.45 - 3.30  Feeding role play

3.30 - 4.00  **Afternoon Snack**:

4.00 - 5.00  **Multi-family Group**: discussion of the previous exercise
Friday

9.30 - 10.30  Adolescents (observed by parents) Internalized other interview

10.30 - 11.00  Morning Snack:

11.00 - 12.30  Parents discuss how the week went (while being observed by adolescents behind screen) followed by similar discussion by adolescents

12.30 - 2.00  Multi-Family Lunch

2.00 - 3.30  **Reconstituted family groups**: Developing survival toolkits for mothers, fathers and young people

3.30 - 4.00  Afternoon Snack:

4.00 - 5.00  **Multi-family Group**: Feedback from families and discussion of future plans