

# Anorexia Nervosa in Adolescence and Maudsley Family-Based Treatment

Kim Hurst, Shelly Read, and Andrew Wallis

Anorexia nervosa is a serious psychiatric disorder that usually occurs in adolescence. The course of the illness can be protracted. Current empirical evidence suggests that the Maudsley Family-Based Treatment (MFBT) is efficacious for adolescents. MFBT empowers parents as a crucial treatment resource to assist in their child's recovery. The authors review the diagnostic criteria and course of anorexia in adolescence, present empirical evidence and key theoretical concepts of MFBT, and provide a case study.

**Keywords:** anorexia nervosa, adolescence, Maudsley Family-Based Treatment

Anorexia nervosa is a serious psychiatric disorder that generally occurs in adolescence, with a median age at onset of 17 years (Steiner et al., 2003; Wentz, Gillberg, Anckarsa, Gillberg, & Rastam, 2009). Prevalence of anorexia is estimated at 0.3%, with rates increasing, particularly in females between the ages of 15 and 24 years, over the last century (Hoek, 2006). Anorexia is more common in girls by 10 to one, increasing to one male for every 20 females by young adulthood (Kohn & Golden, 2001).

For the forthcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM; www.dsm5.org/ProposedRevisions/Pages/EatingDisorders.aspx)*, changes have been proposed for anorexia diagnostic criteria. These potential changes will be focused more clearly on the behaviors that lead to weight loss, making these criteria more clinically relevant. Currently, however, diagnostic criteria for anorexia include (a) a refusal to maintain body weight at or above a minimally normal weight for age and height; (b) an intense fear of gaining weight or becoming fat, even though the individual is underweight; (c) a disturbance in the way one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight; and (d) amenorrhea in postmenarcheal females for three consecutive menstrual cycles. Furthermore, there are two subtypes of anorexia. *Restricting* subtype occurs when the person has not regularly engaged in binge-eating or purging behavior during the period of anorexia. *Binge-eating or purging* type occurs when the person has regularly engaged in binge-eating or purging behavior during the episode of anorexia (DSM [4th ed., text rev.]; American Psychiatric Association, 2000). If weight loss is not reversed, major medical complications such as bradycardia, peripheral edema, and osteoporosis may develop (Mitchell & Crow, 2006).

The causes of anorexia are considered multifactorial with the most common risk factors being genetic predisposition, specific personality traits such as perfectionism, and early

dieting behaviors (Steiner et al., 2003). Adolescence, especially for females, is an illness-specific risk period because of the changes that take place in a young person's body during puberty, leading to an increase in body dissatisfaction that may increase dieting behaviors (Steiner et al., 2003).

Although much of the research purports that anorexia is a chronic illness (average duration of illness, 5–7 years; Beumont & Touyz, 2003), some research has indicated that many young people do achieve full recovery from the illness. Strober, Freeman, and Morrell (1997) conducted a naturalistic, longitudinal study of 95 adolescents with anorexia and found that although illness duration was protracted (ranging from 57 to 79 months), most patients were weight recovered and females were menstruating regularly by the end of the 15–20 year follow up, with 76% of the cohort meeting the criteria for full recovery. They also found that relapse after recovery was relatively uncommon. It is sobering to note that the outcome is not always positive, with anorexia having the highest mortality rate of any psychiatric illness; approximately 10%–20% of individuals with the disorder die within 20 years of onset (Katzman, 2005). It is estimated that about one half of the deaths are due to suicide and one half are due to secondary physical complications of anorexia, particularly cardiac failure (Herzog et al., 2000).

Given the severity and complexity of anorexia, effective treatment is essential to prevent a protracted illness and to reduce potential morbidity and mortality. Anorexia has a profound impact on the lives of individuals with the disorder and their families (Robin, Siegel, & Moyer, 1995; Wallin & Kronvall, 2002). Over the last 25 years, empirical evidence has been accumulated suggesting that family-based interventions are effective outpatient treatments for children and adolescents with early onset anorexia. Maudsley Family-Based Treatment (MFBT) is currently the most promising treatment for adolescents with anorexia (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Treasure, Claudino, & Zucker, 2010).

**Kim Hurst** and **Shelly Read**, Eating Disorders Program, Gold Coast, Robina, Queensland, Australia; **Andrew Wallis**, Eating Disorders Service, The Children's Hospital at Westmead, Sydney, New South Wales, Australia. Correspondence concerning this article should be addressed to Kim Hurst, Eating Disorders Program, Gold Coast, Suite 13, Riverwalk Place, 238 Robina Town Centre Drive, Robina, Queensland 4226, Australia (e-mail: Kim\_Hurst@health.qld.gov.au).

© 2012 by the American Counseling Association. All rights reserved.

## MFBT

MFBT was developed in the 1980s by Christopher Dare and colleagues at the Maudsley Hospital in London (Dare, 1985) and was manualized in 2001 (Lock, LeGrange, Agras, & Dare, 2001). The American Psychiatric Association's (2006) practice guidelines for eating disorders specify MFBT as the evidence-based treatment for children and adolescents. The guidelines of the National Institute for Clinical Excellence (2004) indicate that family interventions that directly treat the eating disorder should be offered to children and adolescents. Support is currently lacking for other outpatient psychological treatments for adolescents (see Lock & Gowers, 2005).

### Evidence for MFBT

Five randomized control trials (RCTs) and several uncontrolled studies have been conducted using the MFBT. The first trial compared family therapy to individual supportive therapy after an initial hospitalization to restore weight (Russell, Szmulker, Dare, & Eisler, 1987). Four groups participated in this trial: adolescents with anorexia for less than 3 years, adolescents with a longer duration of illness, patients with anorexia as adults, and patients with bulimia nervosa. The study concluded that the only difference in treatment outcome was for individuals with a shorter illness, with family therapy achieving a significantly better result for this group. Good outcome, as assessed by Morgan Russell Criteria (Morgan & Hayward, 1988), was indicated if weight was greater than 85% of ideal body weight (IBW) and menstruation had returned in females. When the patients from this study were followed up with after 5 years, the positive results had been maintained for the adolescent patients having the illness for the shortest time (Eisler et al., 1997).

The results of this initial study led to the development of two additional RCTs: a pilot study (Eisler et al., 2000; Le Grange, Eisler, Dare, & Russell, 1992) followed by a larger study (Eisler et al., 2000) that compared, separately, family therapy (i.e., the parents and the young person were seen) with the standard form of conjoint family therapy. The results of the original trial led to the hypothesis that high expressed emotion and criticism would reduce treatment effectiveness, given that the family was expected to attend sessions together. Results from the two studies indicated that overall there was no difference between the two formats of treatment, with approximately 60%–80% of participants achieving weight that was more than 85% of their IBW. Families exhibiting high expressed emotion had better outcomes with the separated family therapy, as predicted. As in the initial RCT, these patients were followed up with after 5 years, and results had been maintained with 75% having no eating disorder symptoms (Eisler, Simic, Russell, & Dare, 2007; Lock, Le Grange, Forsberg, & Hewell, 2006).

Although these results were promising, the number of patients in these studies was low, with variable entry and outcome

criteria thresholds, and treatment was not manualized (Eisler, Lock, & Le Grange, 2010). Two recent trials have addressed these issues by investigating the dose of treatment with a large cell size, comparing MFBT with individual treatment. One of these trials investigated manualized MFBT with 86 adolescents, comparing a shorter dose of treatment (i.e., 10 sessions) with the standard 20 sessions. Results showed that both interventions were equally effective, with positive outcomes that were similar to the previous trials (Lock, Agras, Bryson, & Kraemer, 2005). The criterion for outcome was tightened with the addition of the Eating Disorder Examination (EDE; Cooper, Cooper, & Fairburn, 1989) as an outcome measure. The EDE is a semistructured interview that measures eating disorder psychopathology. Patients with more persistent and severe eating-related obsessional thinking and nonintact families benefited from longer treatment, whereas those with comorbid psychiatric disorders had higher levels of dropout and lower remission rates (Lock, Couturier, Bryson, & Agras, 2006). At follow up between 2 and 6 years, results were similar to those of the earlier trials, with no discernable difference between the groups and 89% of the participants above 90% of IBW (Lock et al., 2006).

In the most recent trial, a large study of 121 participants compared manualized MFBT with an active treatment: adolescent-focused individual therapy (AFT; Lock et al., 2010). The goal of AFT is to address ego deficits associated with anorexia by helping the patient tolerate emotions and prevent starvation. The criteria for outcome were again tightened: To be considered in full remission, a patient needed to have global EDE scores within the normal range and a weight above 95% of IBW. At the end of treatment, there was no significant difference in full remission rates between the treatment groups, with 42% for MFBT patients and 23% for AFT patients; however, the MFBT group had better outcomes at 6- and 12-month follow ups. In the partial remission group (IBW >85%), MFBT was superior at the end of treatment but not during the follow-up periods (Lock et al., 2010). Although both treatments led to improvement, the results from this study indicate that MFBT appeared to improve patients' physical health more quickly than did individual therapy, as evidenced by higher body mass index percentiles in participants at the end of treatment (i.e., at 6- and 12-month follow ups). This is particularly pertinent given the potential physical consequences of anorexia.

Finally, manualized MFBT appears to be effective and acceptable to 78% of patients and families (Krautter & Lock, 2004), and completion rates over 80% were reported in the large studies (Lock & Gowers, 2005; Lock et al., 2010). In addition to the trials mentioned earlier, dissemination of MFBT beyond the treatment development sites in the United States and the United Kingdom appears to be successful (Couturier, Isserlin, & Lock, 2010; Loeb et al., 2007; Paulson-Karlsson, Engstrom, & Nevenon, 2009; Wallis, Rhodes, Kohn, & Madden, 2007).

Further research is required to determine who is more likely or unlikely to respond to treatment; to date, one interesting finding is that early response, demonstrated by weight gain, is the best predictor of remission at the end of treatment (Doyle, Le Grange, Loeb, Doyle, & Crosby, 2010). The theoretical underpinnings, description of MFBT, and a case study follow to discuss and illustrate the application of this model.

## Theoretical Underpinnings of MFBT

MFBT uses the family as a key resource for recovery by mobilizing the parents to take control of the young person's anorexic behaviors. The model is unique in that it integrates theoretical ideas from several established family therapy approaches including strategic, structural, Milan systemic, and narrative (Lock et al., 2001). A core tenant of MFBT is that the child with anorexia has regressed and is not functioning at her or his appropriate developmental level, with normal adolescent behavior arrested by the presence of anorexia (Lock et al., 2001). Therefore, the child is not viewed as being in control of the anorexia behavior; instead, the illness controls the child. To address this, externalization, a narrative therapy technique (White & Epston, 1990), is used to separate the client from the anorexia. Externalizing places problems outside the individual: "the *person* is not the problem, the *problem* is the problem" (White & Epston, 1990, pp. 54–56). Through this separation, the family can begin to perceive the anorexia in a different way and begin to help without blaming and judging the young person for his or her behavior.

MFBT takes an agnostic view of anorexia etiology that is drawn from strategic family therapy (Haley, 1973). The causes of the illness or the factors that produce or predispose the person to anorexia (Madanes, 1981) are not considered a focus of MFBT. Therefore, treatment is not concerned with uncovering the reasons that anorexia has occurred but rather refocuses the family on finding solutions to release the affected child from the illness's grip (Lock et al., 2001).

MFBT emphasizes that parents need to assume an executive position and work with their child to defeat anorexia. This focus is drawn from structural family therapy's understanding that clear boundaries between the parent and sibling subsystems are essential to healthy family functioning (Minuchin et al., 1975). One structural intervention in MFBT is the family meal, which is used in the second session. The goal of this intervention is to clearly establish healthy intergenerational boundaries and parental authority over eating (Lock et al., 2001).

In MFBT, the family is able to find solutions to fight the anorexia, and therefore the counselor resists establishing an "expert" stance and instead defers to the parents' expertise (Lock et al., 2001). In line with the concept of neutrality emphasized by Milan systemic family therapy (Boscolo, Cecchin, Hoffman, & Penn, 1987), the counselor remains neutral in relation to how the family will take charge of anorexia. MFBT deviates, however, from Milan neutrality in

that weight gain and normal eating are nonnegotiable goals of treatment. The MFBT counselor helps the family generate ideas by using questioning techniques rather than being directive. In this way, the family is encouraged to find solutions themselves, rather than to rely on the counselor as the expert (Lock et al., 2001). This method respects the family's own ideas and helps to avoid triggering homeostatic mechanisms that would be met with counterpressure to maintain the system in an unchanged state (Boscolo et al., 1987; Lock et al., 2001; Selvini-Palazzoli, 1974).

## Treatment Phases

MFBT is an intensive, three-phase, outpatient treatment that is usually conducted within 20–24 treatment sessions over a period of approximately 12 months. Phase 1 of treatment (refeeding the patient) targets weight restoration and a return to normal eating. This is achieved by focusing on the dangers of severe malnutrition associated with anorexia and coaching the parents to work together around the issue of the child's food refusal in a firm but warm and consistent way (Lock et al., 2001). A family meal is conducted during this phase, during which the counselor can observe how the family interacts when eating so that the parents can be given assistance in their efforts to refeed their child (Lock et al., 2001). Other key tasks in this phase are to separate the young person from the anorexia via externalization and to align the young person with her or his siblings who can provide additional support and encouragement.

Phase 2 (negotiations for a new pattern of relationships) focuses on encouraging the parents to help their child take more control over eating once again (Lock et al., 2001). This is achieved through carefully negotiated trial periods during which the young person is responsible for her or his eating. For example, the parents would allow the young person to serve her or his own meals or eat certain meals without supervision. As steady weight gain continues and the young person is eating without needing to be persuaded by parents, an exploration into the relationship between adolescent developmental issues and anorexia begins and is the focus of the next phase of treatment.

Phase 3 (adolescent issues and termination) shifts to a focus on the impact anorexia has had on the young person and to the establishment of a healthy adolescent identity that is free from anorexia (Lock et al., 2001). At this point, the young person has achieved stable weight, and the self-starvation has abated. The fundamental assumption of Phase 3 is that the anorexia has interrupted regular adolescent development; the therapist's task is to facilitate a return to this stage of growth. Discussion of other issues is the focus of the sessions; for example, the counselor might address independence, development of romantic relationships, or exploration of career or educational opportunities. The counselor and family support the young person to achieve greater personal autonomy while



working on establishing appropriate intergenerational family boundaries (Lock et al., 2001).

The parents are also able to refocus on their relationship as a couple because the crisis is over. Finally, the termination session explores the family's experience of therapy, with the counselor giving them confidence that they can be successful in handling future problems. The following case study illustrates the treatment phases in greater detail.

### Case Study Using MFBT

Anita was a 16-year-old female at the time of her first presentation of anorexia, with a weight of 83 lbs., height of five feet four inches, 69% IBW, and an 8-month history of amenorrhea. Anita resided in an intact family with a younger sister. She had experienced an 8-month history of increased physical exercise, restricted oral intake, and subsequent weight loss (35 lbs.). Anita's weight loss had occurred by reducing meal portion size, eliminating food groups from her diet, increased involvement in cooking and food preparation, frequent self-weighing, and social withdrawal from peers and family. She also experienced body image disturbance, preoccupation with achieving weight loss, calorie counting, averting thoughts of hunger, increased anxiety, and urges to self-harm. Anita identified several psychosocial stressors that she felt contributed to her mental state and low mood, including ongoing conflict and bullying from her school peers.

### Medical Evaluation and Treatment

Patients with anorexia are subject to a variety of physical and medical complications related to weight loss and malnutrition; therefore, treatment must include ongoing medical and physical management (Katzman, 2005). During treatment, the counselor should consult frequently with the medical professionals involved in the case. Initially, patients may require intensive medical monitoring (i.e., weekly or more) and in some cases hospitalization; these decisions should be made in collaboration with medical professionals.

At her assessment, Anita was medically compromised and required immediate admission to a hospital. A 6-week pediatric admission included nasogastric tube refeeding and cardiac monitoring due to tachycardia (pulse, 30 beats per minute). Anita was discharged at 100 lbs. (83% IBW); however, she continued to lose weight over the next 2 weeks. Subsequently, she became medically compromised again and was readmitted to a pediatric ward for nutritional rehabilitation. Anita's second discharge weight was 104 lbs. (85% IBW) and the family began MFBT, using the three phases described in the MFBT manual (Lock et al., 2001).

#### Phase 1: Refeeding the Patient

In Phase 1 of Anita's treatment, sessions were scheduled weekly. Treatment was initially targeted at weight restoration and normal eating. At the beginning of each session, the counselor met briefly with Anita to weigh her and to establish

engagement by empathizing with her experience of having to gain weight and to eat normally. Recording her weight at the beginning of each session was an integral part of therapy because this set the scene for the tone each session would take (Lock et al., 2001). After this brief 5- to 10-minute period of interaction, the rest of the family joined the session. Anita's weight progress was illustrated via a weight graph; if her weight had increased, Anita's parents were congratulated on their efforts; however, if Anita had lost weight, the information was used to reinvigorate the parents in their efforts to refeed their daughter (Lock et al., 2001).

Anita's family was viewed as the key resource to help challenge the anorexia. The family's motivation was enhanced by the counselor, who emphasized the dangers of severe malnutrition. During the session, the counselor reviewed progress with refeeding by tracking exactly what happened during specific mealtimes, including difficult ones. Anita's parents encountered difficulties when they did not agree on foods and refeeding strategies before meal times. The counselor helped Anita's parents use their expertise in creating high-density meals and reminded them that their daughter's illness was still in a dangerous stage.

During the second family session, the counselor observed a family meal; the counselor coached Anita's parents to be consistent and firm in their requests to get their daughter to eat. The anorexia was externalized to help manage parental frustration with what appeared to be stubbornness and disobedience. The counselor asked the parents to minimize their differences in how they approached getting Anita to eat and to unite consistently from that point forward. In addition to parental empowerment, Anita's sister was encouraged to provide direct support and be sympathetic to Anita's plight.

Given Anita's two previous hospital admissions, her parents were highly motivated to ensure that their daughter would regain health and would not lose weight. Before MFBT began, Anita had been involved in decision making regarding food choices, and this left her vulnerable to anorexia. Regular attempts at negotiating and arguing with her parents around food choices often resulted in Anita refusing to eat. Her parents decided that to ensure weight gain, Anita would need to consume six meals per day, which consisted of three main meals and three snacks. In addition, Anita's parents decided that, until they observed consistent weight gain, they needed to make all decisions about the types, volume, and variety of food that Anita consumed rather than negotiating with her or giving her choices. Her parents also agreed that meal times would be fully supervised so that Anita would not restrict her food intake.

Anita's eating became the parent's central priority; therefore, the family's routine needed to be adjusted. Anita's parents took leave from work for 2 weeks to focus on the refeeding and supervision of their daughter. Among the strategies the parents used to get Anita well were to sit on either side of her during mealtimes, remain calm during times of distress,

and balance firm clear instructions with empathy and respect. The most innovative idea the family used to address the issue of avoided foods was to go out to a different restaurant each week. Anita would be required to order from the menu something she had previously enjoyed before the emergence of anorexia and consume the meal in its entirety. Although Anita initially found the experience to be difficult, she later reported that being surrounded by other people enjoying food made it easier for her to begin to find pleasure in food again.

Anita's sister was asked to refrain from helping her parents with weight restoration; instead, she was encouraged to recognize how difficult the illness was for her sister and to find ways to support her during this period. She found that using distraction and listening to music alleviated Anita's anxiety about upcoming meals. Anita also found that her sister's praise and encouragement during mealtimes made it easier for her to consume her meal rather than give in to anorexia. This strategy was supported by the findings of Lock et al. (2001), who reported that sibling support was important to recovery.

The main challenge for the family during Phase 1 was managing secret exercise. The parents' strategy was to increase supervision and add to Anita's food intake when they discovered that she had exercised secretly. The parents decided that Anita would be required to consume an extra snack immediately after they discovered the secret exercise. After seven sessions, Anita's weight reached 116 lbs. (95% IBW), and the parents were no longer struggling to manage her behaviors. Anita demonstrated a consistent pattern of weight gain and was eating without conflict under parental supervision. The parents reported that they felt more in charge of the anorexia, and Anita appeared to be less vulnerable to the illness, thus allowing the counselor to begin Phase 2.

### Phase 2: Negotiating a New Pattern of Relationships

In Phase 2, sessions were held fortnightly; the goal of these sessions was to encourage the parents to promote age-appropriate activities and eating behaviors for the adolescent (Lock et al., 2001). Specifically, the main task of Phase 2 was to assist the parents to hand over control of eating to Anita in an age-appropriate way and for them to support her in meeting this challenge. The counselor continued to provide support to the parents regarding food and eating issues, with the additional focus on Anita exploring the difference between anorexic and adolescent thinking. The continuing separation of anorexia from Anita facilitated this process. She began exploring age-appropriate interests other than food and eating.

During Phase 2, Anita demonstrated no dietary restrictions that were dictated by anorexia, was able to attend school full time, engaged in exercise, and continued to gain weight. The enjoyment of being with friends and the reduced worry and conflict within the family assisted Anita to begin negotiating adolescence without the anorexia. Anita also reestablished relationships with her peers and began to socialize with them

regularly. Because Phase 2 goals were achieved, treatment progressed to Phase 3.

### Phase 3: Adolescent Issues and Termination

Phase 3 sessions were held monthly, and the focus of treatment continued to shift toward establishing a healthy adolescent identity and restoring the family's life cycle after the intense focus on anorexia. During this phase, Anita worked diligently on establishing an identity that was not entwined with anorexia and her body image; instead, she became more aligned and engaged with her peers rather than with the anorexia. She became more autonomous by obtaining part-time employment and entering into a romantic relationship with a same-aged peer. Anita also began pursuing vocational interests and participating in a training program. During this phase, Anita's weight was stable (118–123 lbs., 100% IBW), and her menstruation cycle had returned to normal. Her parents began to reinvest in their lives and relationship after the intensity of refeeding. Anita's parents were able to spend time together as a couple and engage in activities that they had previously enjoyed. The termination session reviewed each family member's experience of the therapy. Anita reported that she felt relieved that her parents had taken charge of food and eating and believed that if this had not occurred, she would not have recovered as quickly. The parents believed that the treatment had strengthened their family's relationships and reestablished their unity as a parenting team.

## Practice Challenges With MFBT

Although there is a growing body of evidence to support the implementation of MFBT as the first line of treatment for adolescents presenting with anorexia, we, as counselors working with this model, have found that there are several practice challenges in our treatment setting. The first is fatigue for the family. Because of the serious nature of anorexia and the sometimes protracted length of the illness, families can become fatigued with the day-to-day challenges caused by anorexia. It is important for the treating counselor to validate these feelings of frustration and exhaustion, while balancing this with the need for parents to continue to be motivated. An important role of the counselor during these times is to provide hope and reinvigorate the parents to act when they are feeling depleted.

A second challenge with older adolescents is implementing MFBT when the young person had been moving toward individuation from their parents before the onset of anorexia. In most cases of adolescent-onset anorexia, the young person regresses developmentally and needs to be cared for rather than continue to be independent. This can create challenges of adjustment not only for the young person but also for the parents in renegotiating their role as parents of a child with a serious illness. The counselor needs to remind parents that this is only a temporary change in responsibilities and roles;

when the young person is well again, she or he will return to the previous developmental path.

Conversely, after the young person has moved into Phase 2 of MFBT, some parents are paralyzed by the fear that their child will regress if they regain control of their behavior. In these situations, the counselor needs to help the parents focus on what has been achieved, empathize with their fears, and help them see that progress will stall if they do not move forward to a more normal developmental phase for their child. Encouraging the parents to start with a small experiment often helps things move forward with a manageable level of anxiety for everyone. For example, the young person might be allowed to manage eating lunch at school independently for a week or perhaps to prepare her or his own morning or afternoon tea. Such an experiment gives the young person the opportunity to demonstrate what has been learned about the types and volumes of foods needed to maintain weight, and the parents learn to trust that their child can manage greater independence with eating.

One of the most difficult challenges is slow or no weight gain in Phase 1. There are several reasons that this can occur, and hypotheses need to be generated and explored to help the family make progress. Assessing how the family is coping with the task and their acceptance of Phase 1 goals can renew their focus. Ensuring that the parents are in an executive role and working together is essential, as is sibling support for the young person (Lock et al., 2001). It is important for the counselor to fully understand how much control the parents exert over food and anorexic behaviors, their level of persistence, and their level of fear about having conflict around food. Finally, the level of the anorexia often causes the most difficulty and can lead to the occurrence of secretive behaviors (e.g., secret exercise). The first step in reinvigorating the family is to help them learn how to detect and prevent these covert behaviors as they move toward change.

A fourth challenge can be the use of MFBT with single-parent families. Although research has demonstrated that MFBT is as effective for this family constellation, it has been proposed that such families may require a longer treatment time (Lock et al., 2005). A common issue is that single-parent families sometimes have more limited resources than families in which both parents are available. A single parent may, therefore, experience exhaustion more frequently as she or he shoulders the burden of responsibility alone. The counselor needs to be mindful not to be drawn into a coparenting role but rather assist the parent with recruiting other adults in her or his life who can provide support during this process.

Finally, counselor self-reflection is imperative, both individually and via clinical supervision. Working with families affected by anorexia can evoke feelings of distress, frustration, and anxiety in the counselor, and reflective practice is a process that can address and explore transference issues and ensure that these do not have an impact on the fidelity of the treatment. Reflective practice and supervision moderate

these processes and ensure that the core tenets of MFBT are central to treatment.

## Conclusion

Anorexia nervosa is an illness that has a substantial impact on the individual and the family. If it is undertreated, medical complications can arise and the long-term outcome is likely to be poor. MFBT provides an evidence-based approach to outpatient treatment that supports the family in taking responsibility for helping an adolescent client without blaming her for development of the illness. Through the three phases of treatment, the medical, psychological, and family issues are addressed in a sequential way that can lead to sustainable recovery. As emphasized in this article, although MFBT can be highly effective, the treatment is not without its challenges for the family and counselor.

## References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2006). *Treatment of patients with eating disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (n.d.). *Eating disorders*. Retrieved from <http://www.dsm5.org/ProposedRevisions/Pages/EatingDisorders.aspx>
- Beumont, P. J. V., & Touyz, S. W. (2003). What kind of illness is anorexia nervosa? *European Child and Adolescent Psychiatry, 12*, 20–24.
- Boscolo, L., Cecchin, G., Hoffman, L., & Penn, P. (1987). *Milan systemic family therapy: Theoretical and practical aspects*. New York, NY: Harper & Row.
- Bulik, C. M., Berkman, N. D., Brownley, K. A., Sedway, J. A., & Lohr, K. N. (2007). Anorexia nervosa treatment: A systematic review of randomized controlled trials. *International Journal of Eating Disorders, 40*, 310–320.
- Cooper, Z., Cooper, P. J., & Fairburn, C. (1989). The validity of the Eating Disorder Examination and its subscales. *British Journal of Psychiatry, 154*, 807–812.
- Couturier, J., Isserlin, L., & Lock, J. (2010). Family-based treatment for adolescents with anorexia nervosa: A dissemination study. *Eating Disorders: The Journal of Treatment & Prevention, 18*, 199–209.
- Dare, C. (1985). The family therapy of anorexia nervosa. *Journal of Psychiatric Research, 19*, 435–443.
- Doyle, P. M., Le Grange, D., Loeb, K., Doyle, A. C., & Crosby, R. D. (2010). Early response to family-based treatment for adolescent anorexia nervosa. *International Journal of Eating Disorders, 43*, 659–662.
- Eisler, I., Dare, C., Hodes, M., Russell, G., Dodge, E., Le Grange, D. (2000). Family therapy for adolescent anorexia nervosa: The results of a controlled comparison of two family interventions. *Journal of Child Psychology and Psychiatry, 41*, 727–736.



- Eisler, I., Dare, C., Russell, G. F., Szmulker, G. I., Le Grange, D., & Dodge, E. (1997). Family and individual therapy in anorexia nervosa: A 5-year follow-up. *Archives of General Psychiatry*, *54*, 1025–1030.
- Eisler, I., Lock, J., & Le Grange, D. (2010). Family-based treatments for adolescent anorexia nervosa. In C. Grilo & J. Mitchell (Eds.), *The treatment of eating disorders* (pp. 150–174). New York, NY: Guilford Press.
- Eisler, I., Simic, M., Russell, G., & Dare, C. (2007). A randomised controlled treatment trial of two forms of family therapy in adolescent anorexia nervosa: A five-year follow-up. *Journal of Child Psychology and Psychiatry*, *48*, 552–560.
- Haley, J. (1973). *Uncommon therapy: The psychiatric techniques of Milton H. Erickson*. New York, NY: Norton.
- Herzog, D. B., Greenwood, D. N., Dorer, D. J., Flores, A. T., Ekeblad, E. R., Richards, A., . . . Keller, M. B. (2000). Mortality in eating disorders: A descriptive study. *International Journal of Eating Disorders*, *28*, 20–26.
- Hoek, H. W. (2006). Incidence, prevalence and mortality of anorexia nervosa and other eating disorders. *Current Opinion in Psychiatry*, *19*, 389–394.
- Katzman, D. K. (2005). Medical complications in adolescents with anorexia nervosa: A review of the literature. *International Journal of Eating Disorders*, *37*, 52–59.
- Kohn, M., & Golden, N. H. (2001). Eating disorders in children and adolescents: Epidemiology, diagnosis and treatment. *Paediatric Drugs*, *3*, 91–99.
- Krautter, T., & Lock, J. (2004). Is manualized family-based treatment for adolescent anorexia nervosa acceptable to patients? Patient satisfaction at the end of treatment. *Journal of Family Therapy*, *26*, 66–82.
- Le Grange, D., Eisler, I., Dare, C., & Russell, G. F. (1992). Evaluation of family treatments in adolescent anorexia nervosa: A pilot study. *International Journal of Eating Disorders*, *12*, 347–357.
- Lock, J., Agras, W. S., Bryson, S., & Kraemer, H. (2005). A comparison of short- and long-term family therapy for adolescent anorexia nervosa. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*, 632–639.
- Lock, J., Couturier, J., Bryson, S., & Agras, S. (2006). Predictors of dropout and remission in family therapy for adolescent anorexia nervosa in a randomized clinical trial. *International Journal of Eating Disorders*, *39*, 639–647.
- Lock, J., & Gowers, S. (2005). Effective interventions for adolescents with anorexia nervosa. *Journal of Mental Health*, *14*, 599–610.
- Lock, J., Le Grange, D., Agras, W. S., & Dare, C. (2001). *Treatment manual for anorexia nervosa: A family-based approach*. New York, NY: Guilford Press.
- Lock, J., Le Grange, D., Agras, S. W., Moye, A., Bryson, S. W., & Booil, J. (2010). Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Archives of General Psychiatry*, *67*, 1025–1032.
- Lock, J., Le Grange, D., Forsberg, S., & Hewell, K. (2006). Is family therapy useful for treating children with anorexia nervosa? Results of a case series. *Journal of the American Academy of Child & Adolescent Psychiatry*, *45*, 1323–1328.
- Loeb, K. L., Walsh, B. T., Lock, J., Le Grange, D., Jones, J., Marcus, S. U. E., . . . Debrow, I. (2007). Open trial of family-based treatment for full and partial anorexia nervosa in adolescence: Evidence of successful dissemination. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*, 792–800.
- Madanes, C. (1981). *Strategic family therapy*. San Francisco, CA: Jossey-Bass.
- Minuchin, S., Baker, B. L., Rosman, B., Liebman, R., Milman, L., & Todd, T. (1975). A conceptual model of psychosomatic illness in children: Family organisation and family therapy. *Archives of General Psychiatry*, *32*, 1031–1038.
- Mitchell, J. E., & Crow, S. (2006). Medical complications of anorexia nervosa and bulimia nervosa. *Current Opinion in Psychiatry*, *19*, 438–443.
- Morgan, H. G., & Hayward, A. E. (1988). Clinical assessment of anorexia nervosa. The Morgan-Russell Outcome Assessment Schedule. *The British Journal of Psychiatry*, *152*, 367–371.
- National Institute for Clinical Excellence. (2004). *Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders*. London, England: Author.
- Paulson-Karlsson, G., Engstrom, I., & Nevenon, L. (2009). A pilot study of a family-based treatment for adolescent anorexia nervosa: 18- and 36-month follow-ups. *Eating Disorders*, *17*, 72–88.
- Robin, A. L., Siegel, P. T., & Moye, A. (1995). Family versus individual therapy for anorexia: Impact on family conflict. *International Journal of Eating Disorders*, *17*, 313–322.
- Russell, G. F., Szmulker, G. I., Dare, C., & Eisler, I. (1987). An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Archives of General Psychiatry*, *44*, 1047–1056.
- Selvini-Palazzoli, M. (1974). *Self-starvation: From the intrapsychic to the transpersonal*. London, England: Chancer Press.
- Steiner, H., Kwan, W., Shaffer, T. G., Walker, S., Miller, S., Sagar, A., & Lock, J. (2003). Risk and protective factors for juvenile eating disorders. *European Child & Adolescent Psychiatry*, *12*, 38–46.
- Strober, M., Freeman, R., & Morrell, W. (1997). The long-term course of severe anorexia nervosa in adolescents: Survival analysis of recovery, relapse, and outcome predictors over 10–15 years in a prospective study. *International Journal of Eating Disorders*, *22*, 339–360.
- Treasure, J., Claudino, A., & Zucker, N. (2010). Eating disorders. *Lancet*, *375*, 583–593.
- Wallin, U., & Kronvall, P. (2002). Anorexia nervosa in teenagers: Change in family function after family therapy at 2-year follow-up. *Nordic Journal of Psychiatry*, *56*, 363–369.
- Wallis, A., Rhodes, P., Kohn, M., & Madden, S. (2007). Five-years of family based treatment for anorexia nervosa: The Maudsley Model at the Children's Hospital at Westmead. *International Journal of Adolescent Medicine and Health*, *19*, 277–284.
- Wentz, E., Gillberg, C., Anckarsa, H., Gillberg, C., & Rastam, M. (2009). Adolescent-onset anorexia nervosa: 18-year outcome. *The British Journal of Psychiatry*, *194*, 168–174.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: Norton.