Process of change in family therapy for adolescent anorexia nervosa

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Therapeutic models of change

• Models of change and therapeutic modalities
  • Psychodynamic therapy – Changes in reflective functioning and affect regulation
  • Behaviour therapy – Extinction of maladaptive learnt behaviours
  • CBT – Behaviour change leading to improved perception of self-efficacy

• Models of change and family therapy
  • Structural family therapy – Changing family structure/intra-family boundaries
  • Attachment based family therapy – Repairing relational/attachment ruptures
  • Narrative family therapy – Changing self narratives from disempowering life stories to self-narratives that are empowering and self-efficacious

Common versus model specific factors
Common features and functions of psychotherapy

• Common features
  • a helpful relationship
  • a healing setting
  • a rationale or “myth” explaining the client’s problems
  • a “ritual” implied by the myth that is believed to help solve the problem

• Common functions
  • a decrease in alienation through the therapeutic relationship
  • expectations of improvement
  • providing new learning experiences
  • emotional arousal
  • enhancing a sense of mastery and self-efficacy
  • providing opportunities for practice

Frank JD (1961) Persuasion and healing. Johns Hopkins University Press, Baltimore,
Recent common factor accounts

• an emotionally charged bond between the therapist and patient
• a confiding healing setting in which therapy takes place
• a therapist who provides a psychologically derived and culturally embedded explanation for emotional distress

• an explanation that is adaptive (i.e., provides viable and believable options for overcoming specific difficulties) and is accepted by the patient
• a set of procedures or rituals engaged by the patient and therapist that leads the patient to enact something that is positive, helpful, or adaptive

See also:
Common factors in psychotherapy

- **Client factors (40%)**
  - Therapeutic alliance
  - Research
- **Therapist factors (30%)**
- **Expectancy & hope (15%)**
- **Model & technique (15%)**
- **Moderator variable (research)**
- **Dissemination (research)**
- **Service level (research)**
- **Neurobiology temperament (research)**
Short term versus long term goals of psychotherapy

• Short term goals (therapy model specific techniques)
  • Free association in psychoanalysis
  • Diary monitoring in CBT
  • Circular questions in family therapy

• Long term goals (broader therapeutic strategies)
  • Paying attention to behaviours, thoughts and feelings leading to self-reflection and new insights in the patient
### Psychosomatic family model

(Individual vulnerability interacts with specific dysfunctional family transactions leading to ED)

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>ED an expression of interpersonal conflict</td>
</tr>
<tr>
<td>1985</td>
<td>ED an illness of unknown but not family aetiology</td>
</tr>
<tr>
<td>1995</td>
<td>ED an illness with underlying neurobiological vulnerability</td>
</tr>
</tbody>
</table>

**Putative mechanism of change**

- Clarifying intra-family boundaries
- Reducing enmeshment of family relationships
- Facilitating tolerance of conflict
- Blocking the role of ED as a mediator of family conflict

### Illness family model

(The family accommodates to an enduring, life-threatening illness)

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>ED an illness of unknown but not family aetiology</td>
</tr>
<tr>
<td>2015</td>
<td>ED an illness with underlying neurobiological vulnerability</td>
</tr>
</tbody>
</table>

**Putative mechanism of change**

- Raising parental anxiety to promote control of eating
- Strengthening parental executive system
- Changing parental sense of self-efficacy
- Block role of ED as mediator of relationships

### Putative mechanism of change

- Changing the meaning of feeding the child from control to caring
- Changing behavior around eating and reversing effects of starvation
- Addressing maintenance factors (e.g., intolerance of uncertainty)
- Addressing relational/attachment issues where necessary

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**Dare et al., (1990).** The clinical and theoretical impact of a controlled trial of family therapy in anorexia nervosa. *Journal of Marital and Family Therapy, 16*, 39-57.


Short term versus long term goals

…. [the technique of] anxiety induction is a powerful way of developing a focus within which the parents are consistently addressed as the responsible, executive subsystem of the family. This facilitates the development of an appropriate hierarchically structured control system within the family. At the same time, the parental couple also differentiate themselves from the child or children subsystem […] achieved when the parents are able to take control of their daughter’s eating …

This expresses their separateness from their child in an age-appropriate way and thus, paradoxically, the very act of taking control actually enhances the process of differentiation. This differentiation is crucial both for the development of the adolescent as an individual and also for the adaptation of the family

a theory of change in FT-AN
The role of extra-therapy factors

- Client and illness factors (e.g. duration, comorbidity, motivation, family context) 40%
- Therapist factors (e.g. therapist attributes, expertise, service context) 30%
- Hope & Expectancy 15%
- Treatment model & techniques 15%
- Early intervention
- MDT ED Expertise

Therapeutic alliance
## (Some elements of) a theory of change in FT-AN

<table>
<thead>
<tr>
<th>Treatment context</th>
<th>Intervention</th>
<th>Initial goals</th>
<th>Medium t. goals</th>
<th>Longer t. goals</th>
<th>Predisposing/ maintenance factors</th>
<th>Relational frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team/service characteristics</strong></td>
<td>Assessment of medical risk</td>
<td>Creating a safe base for treatment</td>
<td>Changes in eating behaviours leading to improved nutrition</td>
<td>Increase tolerance of uncertainty</td>
<td>Intolerance of uncertainty</td>
<td>Dependent relationship early in treatment (family/therapist)</td>
</tr>
<tr>
<td><strong>MD expertise</strong></td>
<td>Psychoeducation about the effects of starvation</td>
<td>Hope Expectancy</td>
<td>Reduction of effects of starvation</td>
<td>Reduction of effects of starvation</td>
<td>Anxiety</td>
<td>Dependent relationship early in treatment (parents/child)</td>
</tr>
<tr>
<td><strong>Treatment philosophy</strong></td>
<td>Externalising conversations</td>
<td>Reduction in guilt and blame</td>
<td>Reduction of effects of starvation</td>
<td>Changes in self-perception and self-esteem</td>
<td>Achievement orientation</td>
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<tr>
<td><strong>Referral process</strong></td>
<td>Engagement with whole family incl. young person</td>
<td>Family shared sense of purpose</td>
<td>Changes in parental sense of self-efficacy and locus of control</td>
<td>Taking responsibility for future progress</td>
<td>Hostile critical relationships</td>
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<tr>
<td><strong>Therapist characteristics</strong></td>
<td>Activation of parenting pattern</td>
<td>Activation of parenting pattern</td>
<td>Motivation to change</td>
<td>Reduction of effects of starvation</td>
<td>Taking responsibility for future progress</td>
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<tr>
<td><strong>Expertise</strong></td>
<td>Reframe meaning of feeding</td>
<td>Shift in locus of control</td>
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<td>Insecure attachment relationships</td>
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<td><strong>Warmth</strong></td>
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<tr>
<td><strong>Empathy</strong></td>
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<td><strong>Congruence</strong></td>
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<td><strong>Difference in family and therapist time frame</strong></td>
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What is missing from the above account

• A lot
• Empirical evidence
• Having appropriate measures of mediating mechanisms
• Understanding where the neurobiological predispositions fit
• Understanding of the “roadblocks” when therapy does not work
• Understanding how the process of change overcoming “roadblocks”
• And a great deal more