TEST of TIME

‘An Integrated Treatment Program for Anorexia Nervosa’. Ronald Liebman Salvador Minuchin, & Lester Baker. American Journal of Psychiatry 131:4 April 1974.

Reviewed by Dr Shelagh Wright, (3911 words).

INTRODUCTION

30 years ago Liebman and colleagues described the use of a family meal as part of an integrated treatment approach for anorexia nervosa.

In my review of this paper, I will describe and discuss the ideas laid out in the paper in terms of the understanding of anorexia nervosa at the time: attempt to place the ideas within the context of current language and paradigms; and discuss the points raised about the specifics of the approach in the light of current treatment ideals. Finally I will comment on whether or not I think the paper stands ‘the test of time’.

THE PAPER

Leibman et al describe a model of treating anorexia nervosa using ‘behavioural conditioning’ within the context of ‘structural family therapy’. Included in the description are both an inpatient phase and an outpatient phase. The authors state that the key to this approach is the early involvement of the family, although in fact the family were excluded from the hospital programme and asked not to discuss the programme with the patient. The authors claim that early and direct involvement of the family promotes significant and rapid weight gain, whilst continued involvement of the family in therapy during the outpatient phase facilitates the necessary restructuring of the family to prevent relapse.

The inpatient phase described in the paper involved physical activity being contingent on weight gain. It also involved the therapist periodically having lunch with the patient. During these lunches we learn that the therapist tells the patient that he is hungry, his stomach hurts and he feels light-headed. He says it feels

good to eat and be satiated. No attempt is made to get the patient to eat her lunch. The therapist asks permission to eat a small part of the patient's food, such as a piece of carrot. He then offers to share part of his lunch with her. This procedure is said to enable the therapist to ascertain the level of negativism and anorexia manifested by the patient. It also provides an opportunity to relate to her over the issues of sharing and eating food. During these lunches the therapist also tries to engage the young person in a conversation that could form the foundation of later therapeutic work.

Also described in the paper is a family therapy lunch session, to include both parents, the patient's siblings, the 'family psychiatrist' (therapist) and the paediatrician, and to be held at the end of the first week of the in-patient phase. This would be the first time that the parents meet the 'family psychiatrist' and marks the beginning of the transition to the outpatient treatment phase. At the end of this session a weight goal is established for discharge.

The authors report that the family therapy lunch sessions and the family tasks set in therapy are vital to the outcome of therapy. They outline the goals of the family therapy lunch session thus:

1) To enable the patient to eat in front of her parents without getting into a battle, so that they could all have a new experience around food and eating. In the authors (Liebman et al) opinion the eating needs to be a private matter between patient and therapist to prevent unhelpful intrusions from the parents.
2) To redefine the presenting problem and dismantle the family's myth that they are fine except for the presence of their sick child. This moves the child from the rigid role of being the sole repository of all the family's problems to there being a recognition of the interpersonal transactional conflicts that exist between the parents and their child. This decreases the patient's centrality and the manipulative power of her symptoms.

Once the patient is discharged the 'family psychiatrist' assumes responsibility, with the paediatrician in support. In the outpatient phase social activities are contingent on weight gain. The general goals of the outpatient phase are described thus:

1) To eliminate the symptom of refusing to eat and stimulate progressive weight gain.
2) To shed light on the dysfunctional patterns in the family that reinforces the patients' symptoms.
3) To change the structure and functioning of the family system in order to prevent a recurrence of the symptoms or the development of a new symptom bearer.

The parents are told very clearly that it is their responsibility to uphold the treatment paradigm. If the patient refuses to eat and loses weight then this is seen to indicate that the parents are not working together.

TREATMENT FOR ANOREXIA NERVOSA - THEN AND NOW

Thirty years on, how far are the ideas of Leibman, Minuchin and Baker still relevant to work with families that present with a member with anorexia nervosa? At the time of writing this paper, the authors report, a significant proportion of the patients they studied had continued, post-discharge, to lead restricted lives. They state strongly their belief that the therapeutic focus needs to be the patients' family. They argue that, paradoxically, whilst investigators of anorexia nervosa have consistently described prominent family psychopathology few attempts had – at that time - been made to modify the family environment to which the patient must return after discharge from the hospital. Minuchin at that time had been the only researcher/clinician to report on the direct confrontation with a family's habitual interactional patterns to alleviate the symptoms of anorexia nervosa, (Minuchin et al 1970, 1971, 1973, 1974).

These early writings about family psychopathology and the focus on the family in treatment seem to have been the basis for many clinicians' belief that families are responsible for the development of eating disorders.

The current treatment context for anorexia nervosa is that while researchers continue to try to establish the efficacy of family therapy in the treatment of eating disorders, the emphasis is on mobilizing family resources rather than treating family dysfunction. Motivational techniques have become an important component to many therapeutic approaches with an aim to help individuals and families feel more empowered in their own recovery process. Geller has described the therapist's motivational stance as being important in engaging people in therapy. (Geller 2001) It is also being argued that brief intensive multiple family interventions provide an important alternative to engaging families in conventional treatment (Stratton 2005).

'Behaviour conditioning' is an approach that very few clinicians nowadays would admit to using outside the treatment fields of fears or addictions. However I would argue that the principles of behaviour conditioning can be identified in many current treatment programmes. For example, most inpatient units attempt to restrict the exercise and activity levels of the patients; there will be specific physical activities that are dependant on the patient achieving certain weight markers; an exercise regimen will be prescribed; and outings will be of a sedentary nature, for example going to the cinema. Weekend leave periods will also be dependent on achieving an adequate level of physical health, which is of course closely linked to weight gain. Some units even refuse weekend leave until the patient is within an agreed healthy weight range. Other more 'traditional' units still use bed rest, commodes, and reward systems to encourage their patients to cooperate with treatment.

While I hesitate to link ‘behavioural conditioning’ and motivational enhancement, the similarity in both approaches is the sowing of a seed in the mind of the patient, that change could be a good thing. For the ‘behavioural conditioning’ approach it is a direct equation: if the patient behaves in a certain way she will be rewarded with items she wants (for example, if she gains weight then she can have visitors). Whereas for the motivational enhancement approach: if the patient continues to behave in a certain way then life will be less rewarding for her (for example, if the patient continues to lose weight or maintain a significantly low weight then she remains frail and cannot enjoy her life, attending school or holding down a job). Both approaches highlight the negative consequences of the ‘offending’ behaviour and promote the positive consequences of changing this behaviour. The key difference is that with ‘behavioural conditioning’ the patient does not experience a sense of being in charge of her choices, whereas with motivational therapy the aim is for change to emerge from within. With the motivational approach the young person involved is able to identify her areas of motivation and can feel in charge of her own treatment and what resources she has available to her.

Treatment professionals nowadays often discuss with the patient the ways in which anorexia nervosa is restricting her life and whether or not she is comfortable with those restrictions (motivational interviewing techniques); the aim is to help her to restrict her anorexia, rather than her life. This sounds very similar to the aim of Liebman and colleagues to give the patient an increasing sense of autonomy and responsibility for her physical state. Is the motivational approach the modern-day equivalent of the old ‘behavioural conditioning’ approach?

THE FAMILY MEAL SESSION

In the last 30 years much has been written about the efficacy of family therapy in the treatment of eating disorders (Szmuckler et al 1985 & 1987, Dare et al 1990, Le Grange et al 1992, Eisler et al 1997); and more recently the use of multi family group therapy with families where there is an eating disorder (Dare & Eisler 2000, Le Grange & Lock 2001, Scholz 2005). But there has been little exploration of the use of family therapy lunch sessions. In fact, many units still exclude parents from their child's treatment. Siblings are often not considered at all, or excluded for reasons related to ideas about exclusivity, rivalry and fears of contamination. It can be argued, however, that siblings provide the patient and the parents with a model of how they can relate together without the use of anorexia nervosa.

Leibman and colleagues describe how parents are excluded from the eating side of treatment, but then viewed, if the patient fails to gain weight, as not working together. This does seem to be a contradiction, as the responsibility for the treatment to work is placed with the parent, although they are not to be involved in getting their child to eat. This is different from the current ethos, for the younger patient particularly, where the focus of therapy is often to empower the parents to feed their child successfully. As the child gets older, more responsibility for eating is placed with them, and the responsibility of the parents is to support their child in eating, by providing them with appropriate food and encouraging them during and after meals. Placing sole responsibility with the parents can serve to compound their feelings of shame and inadequacy, and to discourage the young person from taking any responsibility. The responsibility needs to be shared between the young person, the parents and the clinician(s) working together in an atmosphere of trust and respect, so that sensitive issues can be explored and resolved without individuals feeling blamed.

Today most adolescent eating disorder units allow relatively free access between family and patient, with family therapy seen as an essential component to the

treatment of anyone under the age of eighteen years. However, families are still mostly excluded from mealtimes until such time as the patient is preparing for home leave. There is an obvious gap here between what as clinicians we expect parents to be able to do, and what we allow them to be involved with. Getting their child to eat has been a key difficulty for them yet this is the area with which they receive the least help.

Eating with the patient is often managed by the more junior members of the in-patient staff who invariably have the least knowledge, least training and least experience. Some units consider the therapist eating with the patient as undermining the therapeutic relationship between therapist and patient. Other units allow therapists to eat with patients but only as an observer. Meals that the families do attend are mostly unstructured and unsupervised by staff. This means that in general any problematic behavioural patterns between the parents and child are not detected and not addressed. All these meals can do is reinforce unhelpful family interactions. The ward staff are then generally reliant on the feedback from the parents and the child to determine the success of the meal. This seems to be quite different from the approach described by Liebman et al where the therapists and psychiatrists were directly and strategically involved in eating with the patients and her family.

It is important to consider the relationship between the ward staff and the patient as well as the relationship between the ward staff and the parents. In my experience some parents feel that they are openly blamed for the condition of their daughter, while others sensed the staff's underlying belief that their child's condition is due to their inability to do what is required. There is a serious issue here about professionals' ability to understand the family interactions, as well as their effects on the development, progression, and recovery of anorexia nervosa, without blaming the family, and parents in particular, for the illness. Most parents already have feelings of failure or inadequacy when they bring their child for

admission. This is mixed with anger towards the child for being ill and the ward staff for being able to get their child to eat when they had failed to do so. Inexperienced and inadequately trained staff are rarely able to process this experience without becoming angry themselves and blaming towards the parents. This can often mean that the conflict within the family becomes the conflict between the family and the ward staff. Excluding the parents from the essential components to the in-patient treatment can compound these feelings, perpetuating this conflict and the symptomatic behaviour of the patient. This would then make it a more complex process for the parents to acknowledge that they had experienced any difficulty when eating the meal with their child.

RESPONSIBILITY FOR EATING

Whilst it is undisputed that young people with anorexia nervosa need to eat and gain weight in order to recover, how that is achieved is much debated, and the approach taken is often dependent on the age of the young person. Some treatment centres place full responsibility with the parents, which invariably results in many battles between the parents, between parent(s) and the child and between the child and her siblings. Other centres place responsibility on the young person, with the threat of hospitalisation as the likely outcome of her failure to comply. Liebman and colleagues suggest that whilst the clinician maintains authority over the treatment, there is in essence a sharing of the responsibility, in that the young person has the responsibility to gain sufficient weight to be allowed specific activity rewards: whereas the parents have the responsibility of restricting activity if sufficient weight gain is not achieved. Young people often feel motivated to eat sufficiently if it means they can retain responsibility over their eating. This is not to take the view that all conflict should be avoided; parent(s) need to feel empowered to manage their child's behaviour, while the child needs to feel confident to express themselves in a variety of ways,

apart from not eating, as well as feeling that they have some age-appropriate authority over other issues.

What did not seem to be considered in this 1974 paper was how the young persons' feelings might be related to their difficulty in eating. It is more widely recognised now the role that feelings play in the development of and recovery from anorexia nervosa. Current ideas are around the development of anorexia nervosa as one way of suppressing strong feelings or avoiding the consequences of expressing them more directly. The recovery process is seen to involve learning to identify strong feelings as well as expressing them appropriately, (Willoughby2005).

Liebman (1974) and colleagues used family therapy lunch session as an opportunity to observe family interactions as well as agree plans and goals. Minuchin has suggested that the interactions of the family around the meal do indeed demonstrate how the family will interact generally around other issues. If this is the case, then one might wonder not just why the family meal seems to have become lost along the way in family therapy for anorexia nervosa, but also why it has not been a component of family therapy in areas other than anorexia nervosa.

Family therapy is currently the only evidence-based treatment for adolescents with anorexia nervosa, but the literature describing what the therapy involves is limited. Whether or not family therapy techniques can be taught via a manual is also debated by key researchers/clinicians in the field. However, it is not these researchers and clinicians who sit down to eat with the patients six times a day; it is the parents, at home, or ward staff, in hospital, (mainly the nurses, and more often the junior untrained nursing staff). Maybe this is why interventions such as the family therapy lunch session rarely occur in inpatient treatment centres because senior staff are so little involved with the patients' actual eating.

Nonetheless, the family therapy meal session is the most interesting component of the treatment approach described in this paper and may be the most under-utilized component of treatment today. In-patient services have a unique opportunity to work with patient and their families *around the table* to address all the aspects of change outlined earlier; yet they invariably fail to do so. In families where a child has anorexia nervosa, the art of eating a meal with the child is the key issue that parents struggle with. It is also the key part of in-patient treatment- one that causes the most conflict between patients and staff - yet it has become the area least focused on, mainly managed by the most junior of staff. Is it that in our wish to focus on the wider aspects of the eating disorder that we have lost our way in helping our patients to eat? We are all in agreement that our patients need to eat in order to sustain a full recovery, as well as being in agreement that eating is not enough. However, we seem not to put as much thought and energy into the eating part of treatment as we put into the therapy part of treatment.

The family therapy lunch session has recently resurfaced within the context of multi-family group therapy. It is used in this context as part of an intensive day treatment where families can sit together, with the input of a clinician, to help support parents in supporting their child to eat. In this context there is an expectation that the parents will be successful eventually.

Perhaps the issue here is that there has become a large divide between what happens in research and what happens in the clinical setting. As the field has progressed and become more specialized, so have the senior clinicians/ researchers. Research can take up so much time and energy it can be difficult to combine research and clinical roles. This can mean that professionals often have to choose between a research post and a clinical post, and often cannot have both. This means that those who choose the research career path can become quite disconnected from the people and issues relevant to the clinical setting.

So, to the question *Does this paper stand the 'Test of Time'*? In some ways it does, in its recognition of the importance of families being involved in treatment; and in some ways not, in that today families are involved in new ways, with parents encouraged to be part of the treatment team, partaking in shared treatment planning and decision making for their child.

In order to recover, patients need to be able to manage an adequate diet at a healthy weight over their lifetime and work therapeutically to address and sufficiently resolve the issues that provoked and/or maintained the illness. Only addressing one part of the equation generally leads to a relapse. If, as has been suggested, the family interaction around the table reflects the family interaction generally, then this would be the obvious place to address both sides of the recovery equation. In this seminal paper, Liebman and colleagues clearly recognized this. Whilst the principles stand the test of time, the practice does not.

Dr Shelagh Wright

Systemic Psychotherapist

References.

Dare, C. Eisler, I. Russell, G. Szmuckler, G. (1990) *'The clinical and theoretical impact of a controlled trial of family therapy in anorexia nervosa'* Journal of Marital and Family Therapy. Vol.16:1:39-57

Dare, C. & Eisler, I. 2000, *A multi family group day treatment programme for adolescent eating disorder.* European eating disorders review 8:4-18

Eisler, I Dare, C. Russell, G. Szmuckler, G. le Grange, G. Dodge, E. (1997) *'Family and individual therapy in anorexia nervosa: a five year follow-up'* Archives of General Psychiatry. Vol 54:1025-1030

Geller, J Williams, K and Srikameswaran, S (2001) *Clinicians Stance in the treatment of Chronic Eating Disorders,* European Eating Disorders Review 9: 365-373

le Grange, D. Eisler, I. Dare, C. Hodes, M. (1992) *'Family criticism and self starvation: a study of expressed emotion.'* Journal of Family Therapy. Vol 14:177-192

le Grange, D. Eisler, I. Dare, C. Russell, G. (1992) *'Evaluation of family treatments in adolescent anorexia nervosa: a pilot study.'* International Journal of Eating Disorders, Vol:12:4:347-357

Liebman, R. Minuchin, S. & Baker, L. 1994, *'An Integrated Treatment Program for Anorexia Nervosa'.* American Journal of Psychiatry 131:4.

Lock, J. le Grange, D. Agras, WS. Dare, C. (2001) *Treatment Manual for Anorexia Nervosa: a Family-based Approach.* New York, Guildford

Minuchin, S. 1970, *'The use of an ecological framework in the treatment of a child, in The Child and His Family'*. Ed Koupernik, C. New York, John Wiley & Sons.

Minuchin, S, 1971, *'Anorexia Nervosa: interactions around the family table'*. Institute for Juvenile Research, Chicago.

Minuchin, S. Baker, L & Liebman, R. 1973, *'Anorexia Nervosa: successful application of a family therapy approach'*. Paediatric Res. 7:294.

Minuchin, S. Baker, L. & Rosman, B. 1973, *'Psychosomatic illness in children: a new conceptual model'.* Philadelphia child Guidance Clinic.

Minuchin, S. 1974, *Families And Family Therapy*. Cambridge. Mass. Harvard university Press.

Scholz, M. Rix, M. Scholz, K. Gantchev, K. & Thomke. V. 2005, *'Multiple family therapy for anorexia nervosa: concepts, experiences and results'.* .Journal of Family Therapy. Vol 27:2 132-141

Stratton, P. 2005, *Report on the evidence base of systemic family therapy.* Prepared on the behalf of the academic and research committee of the association of Family Therapy.

Szmuckler, G. eisler, I. Russell, G. Dare, C. (1985) *'Anorexia Nervosa, Parental Expressed Emotion and Dropping out of Treatment'* British Journal of Psychiatry Vol.147:265-271

Szmuckler, G. Berkowitz, R. Eisler, I. Leff, J. Dare, C. (1987) *'Expressed Emotion on Individual and Family Settings: A Comparative Study'* British Journal of Psychiatry Vol. 151:174-178

Willoughby, K., Ayers, S., & Lask, B. (2005, 5th April 2005). '*The Recovery Process in Anorexia Nervosa'.* Paper presented at the The Seventh London International Eating Disorders Conference, Imperial College, London.