# Family Therapy and Anorexia Nervosa: treatment of choice?

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Family Therapy in the treatment of Anorexia Nervosa has evolved over a number of years, and is a complex package of theoretical assumptions and interventions (Dare, 1985, Eisler et al, 2000). One of the major assumptions of this treatment is that viewing the family as a whole gives a unique insight into the family's dynamics and interactions. However, little is known about the changes that take place within the family during the recovery process, whether these changes are a necessary condition for this recovery, are a result of improvement in the patient, or indeed if it is the family therapy that has enabled these changes to take place. In addition little is agreed with regard to what format the 'family therapy' takes in each instance of treatment. Recent attempts have been made to standardize 'family therapy' through the development of a manualised approach. (Lock & le Grange 2001)

Family Therapy like people comes in many shapes and sizes: so when the terms 'family therapy' and 'treatment of choice' are used, what do they actually mean?

At the 2003 London international conference for Eating Disorders a debate workshop was presented on 'Family Therapy treatment of choice' The workshop provoked an interesting debate, however did not define the term 'Family Therapy' or the term 'treatment of choice'.

For constructive discussion to take place around this issue there does need to be some agreement about what is 'family therapy' in the context of eating disorders and what is meant by 'treatment of choice'. In attempt to answer these questions I surveyed the membership lists of EDnet (a group of eating disorders clinicians in the UK) and AFT (the Association for Family Therapy): these numbers are around 2000 individuals. From this survey I received back 28 completed questionnaires. Whilst being disappointed, I

was struck by the poor response and wondered what made it so hard for clinicians to be part of something that may help define the terms used in their clinical work. Is it that generally people do not think about the terms that they use, do not have time, or have higher priorities, or are these terms so ingrained in our language that we do not think about what they mean? Or indeed is it too challenging to ask questions about what we as clinicians actually 'do' in the room with our patients.

From the few responses there was little or no agreement about who gets offered family therapy and what that therapy involves. There was no suggestion that family therapy was offered for particular clinical presentations or even chosen from a selection of available therapies. The clinicians offering family therapy were not all qualified or registered as family therapists and were more likely to be psychologists or psychiatrists than family therapists.

Family therapy is a developing profession trying to place itself legitimately in the field of Mental Health. It appears to be competing for a place in mental health care against more traditional psychiatric and psychological interventions such as pharmacological treatments, Psychoanalytical Psychotherapy and Cognitive Behavioural Therapy (CBT), (Clancy, C.M. 2005), (Stratton 2005). Psychoanalysis and CBT are more established interventions in mental health care; for adults generally; are being used widely with adolescents; but on the whole when researched, have no higher efficacy than Family Therapy – although it has to be said that researching psychotherapeutic interventions is minimal and raises many difficulties in terms of applicability to clinic populations. For Family Therapy to be a serious contender in the treatment of eating disorders then the clinicians and researchers delivering and developing it need to be able to define the terms within a specific set of parameters for the eating disordered population.

The issue of ‘treatment of choice’ is a more difficult term to address as it suggests that if all possible treatments were available then family therapy would be selected as the preferred treatment, whereas it is rarely if ever the case that there are treatments to choose from. Family therapy seems to have been placed in this ‘treatment of choice’ position because it was the first to undertake a randomized controlled research study that showed that family therapy was a useful intervention to a specific group of patients with anorexia nervosa. No other psychotherapeutic approach can claim this. As a result family therapy is the only therapy that has the category B in the NICE (National Institute for Clinical Excellence) guidelines (Category B is given where were ‘well conducted clinical trials’ have been done). In reality family therapy is most often used in conjunction with other therapies for example individual psychotherapy, (art therapy and group therapy may also be a component for inpatient treatments); therefore being able to differentiate what is the agent of change for the patient would be difficult to determine. Current research study designs have focussed on comparing one specific individual psychotherapy with family therapy or a specific individual psychotherapy with or without the use of medication. Perhaps a more useful design would be to compare family therapy with one type of individual therapy and family therapy with another type of individual therapy, with or without medication to determine which the most effective combination is. Then it may be possible to make a statement about what treatment combination would be chosen above others.

There is a definite need for us to define our terms if we want to make bold claims about the place a particular intervention has in the overall treatment of our patients. We can only do this if the majority of clinicians are willing to participate in research/audit of not only the interventions but also the terms we use to describe them.

References

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