THE IMPORTANCE OF FAMILY THERAPY IN THE TREATMENT OF CHILDREN AND ADOLESCENTS WITH ANOREXIA NERVOSA

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ABSTRACT
Anorexia Nervosa (AN) is a serious psychiatric disorder that manifests physically, resulting in severe detriment of the individual's appearance and psychiatric profile. Among the predisposing factors of AN that cause an individual to be susceptible to its manifestations include genotypic influential risks, psychosocial and interpersonal parameters can cause the ailment's inception. Moreover, from the somatic perspective, any alteration or substantial changes to the neural networks can prolong the duration of the illness. Advanced milestones in the therapeutic approach and treatment of this illness, especially in the adolescent age group afflicted with Anorexia Nervosa highlights the paramount benefits of implementing a specialised family oriented/based intervention. Adults suffering from Anorexia Nervosa have a plausible opportunity to experience recovery or dramatic improvement, paying close attention that there are no specific methods that take precedent in adult therapy. Furthermore, an eclectic combination of both guided nourishment and psychotherapeutic techniques specific for the treatment of Anorexia Nervosa have yielded promising results. To properly approach and treat this multi-faceted illness, an in depth comprehension of the causative biological and psychosocial mechanisms, must be attained modification and implementation of prevention and early interventional protocols and procedures, all the latter while grasping a more catered targeting strategy for treatment through an in depth comprehension of the disease's specific pathophysiology and mechanism.

Keywords: Eating Disorders, Anorexia Nervosa, Family-based treatment.

INTRODUCTION

Anorexia Nervosa is quite the unique as well as serious mental disorder which does not discriminate against age groups, gender, racial background, sexual predilection, and ethnic origin; in spite of all of these wide at risk groups, adolescent and young adult females are especially at risk. The characterisation of the disease encompasses physical dysmorphia and an exaggerated intense fear of gaining weight. [1,2] These underlying factors cause extreme dietary restriction or other endangering weight loss behaviours and habits as purging or excessive physical training [3,4]. The psychiatric concern with this disease is its disturbance to the cognitive and emotional functioning of people with the disorder. This can lead to life threatening comorbidities from the somatic and the psychiatric domains [5]. The disease in the age profile of older adolescents and adults tends to follow a protracted and relapsing course, leading to elevated levels of disability, and in worst cases mortality when no interventional methods or treatments are applied [6]. Also, more mild forms of the illness as sub-syndromal anorexia nervosa are matriculated with severe health outcomes. The overall outlook of the disease cripples the person's quality of life while placing a heavy burden on the individuals, families and society [7].

For the majority of people suffering from anorexia, an autonomous drive takes over the will of the anorexic individual where

they are compelled to appease others in an effort of realizing their self-worth which is a dependent variable of other's approval. In their quest to achieve self-recognition for their self-image, they become trapped in an endless physical and psychiatric struggle that no amount of extrinsic recognition can satisfy [7]. The disease is not just limited to a distortion in cognition, but also the emotional from the context that a root of the causative factors resides on the notion that a deficiency in the sense of self, which stems from distortions in conceptual development, body image, and individuality [8,9]. The conclusion of this physical and cognitive struggle is extreme emotional turmoil, physical debilitation, and inevitably death caused by the blind pursuit of a helpless person. Anorexia nervosa has no specificity regarding the age of onset, but the age group between early and mid-adolescents are usually high. The end result of the disease progression and resolution is different across the age brackets, with a higher inclination of documented full recovery accompanied by lower mortality in adolescents more than in adults (mean mortality of 2% vs 5%) [7, 10].

OBJECTIVES

A comprehension of the causative factors whether intrinsic but more so on the extrinsic influence that conceives the individual to unwillingly and involuntarily succumb and pursue habits that develop into the manifestations of Anorexia Nervosa.

Understanding the possible motive of family influence and their role in the onset of Anorexia, while addressing the variabilities of socio-cultural demographics that shape the anorexic's perception of themselves, based on studies that evaluate the relation between family stability and atmosphere against the systematic manifestation of Anorexia Nervosa.

Evolution of the disorder is dependent on the sustained support of a family atmosphere that aims to benefit the patient and in the event that the family's presence will jeopardize the patient's prognosis, protocols must be put into action by the medical personnel overseeing the patient's treatment to isolate the patient from a sabotaging family environment.

Utilizing the family model at a moment of crisis, or an intensified moment of the patient's identity regarding the emotional dependency and how the family will become a retainer of the patient's sanity and sense of reminder to their identity.

Recognition that Anorexia Nervosa is both a somatic as well as a psychiatric illness, which needs to be addressed as a serious medical condition and that the initial treatment of the physical symptoms is paramount in preventing the progression to serious life threatening physical consequences.

The structure of therapy and what are the most practiced procedures that establish the stages of intervention, and how the family will play an active role in the rehabilitative process of the patient. This works hand in hand with setting progressive and gradual milestones based on feedback, empowerment, and encouragement.

Evaluating the outcomes of preferred methodologies while highlighting a series of challenges or dilemmas that therapists are prone to face during Family Behavioural Therapy (FBT); In the end the duty is that of the therapist to ensure the best mode of therapy and how focused the family will be on the interventional process depending on the progress of the patient.

The role of the family in the genesis of Anorexia Nervosa

A multitude of reputable scientific literature had been intrigued regarding the various facets regarding the involvement of the families of patients diagnosed with anorexia nervosa. What is the evident role of the family in terms of etiopathogenesis of the disorder,

what are the note-worthy characteristics that cause the genesis of the disorder; finally, which recognizable variables can impact the prognosis and the response to treatment of the disorder [11]. Numerous studies have identified the familial factors that interfere and influence the etiopathogenesis of anorexia nervosa, highlighting the family's part in the appearance and progression of this pathophysiological/psychiatric disorder [12].

Several authors establish varied theoretical standpoints in identifying the potential role of family members, unfortunately, observing the family characteristics of patients with anorexia nervosa is a gruelling task given the multitude of applied methodologies pertaining to the diversity in the socio-cultural and demographic presentations of the patients studied. The main influence behind the evaluation of the patient and the family is due to in part of the onset of a crisis situation secondary to the illness that drives the patient and the family to seek treatment. Whether problems manifesting from dependency issues, a need for autonomy, a sense to earn a secure and bolstered identity, constructs vital factors that revolve around individuation-separation and can place an unsurmountable burden on the course of the illness. That is why the relationship and attitude of the patient to their family during the process of evaluating the problems, depends on the phase of treatment. During the acute phase, anorexic patients are in a state of self-denial of their illness. An innate desire to be favoured and acknowledged by the family appears during the course of the treatment. An evident attitude of hyper-compliance towards the therapist, creates an obstacle in identifying any underlying familial issues. In the case of toxic family atmospheres or conflicting families is more so described in anorexic-bulimic patients as well as bulimic patients [12,13].

Characteristic variables identified in patients with anorexia nervosa regarding familial interaction as per Minuchin & Coll. identified that there was evidence of overprotectiveness, a deficiency in conflict resolution, and the rigidity in lack of accordance to individual boundaries [14]. As in the case in Italy, Mara Palazzoli-Selvini spanning the systemic model and foundationally sustaining that the anorexic patient constitutes the equilibrium and homeostasis of the familial architecture [15]. For the majority of therapists, it is obvious that achieving a state of independence, individuality and attaining one's autonomy is an arduous task for a patient with anorexia nervosa. All of the previous themes are common place during the adolescent period; in fact, this is the time period where the individual is most prone to vulnerability from both the familial and individual recognition domains [12].

Family factors that influence the prognosis and the response to treatment

An agreed upon observational data based on epidemiological studies on the premise of the general population and those within the clinical demographic is pertaining to how anorexic patients seek medical observation at a minimal rate in correspondence to the severity of the disorder. Based on the documented manifestations of the disorder, patients who seek treatment have usually been inflicted with the illness for a long duration of time. Furthermore, it is quite a painstaking task for parents to convince their child to seek medical evaluation and treatment. This is evidenced in the cases where the familial factors tend to anticipate and or delay the onset of influence and treatment, prolonging the anticipated results. The earlier the diagnosis, the more promising the prognosis and course of the illness, while minimizing the chronic effects of the disorder with a facilitation of the therapeutic process. It is evident that the widespread practice of isolating an anorexic patient by hospitalization above all alternative modes of treatment, is the most

accepted approach in managing the evolution of the disorder if familial influence is possibly negative [12]. The term "parentectomy" applied by Vandereycjen and Pierloot [16] while analysing the response to treatment of a group of anorexic patients, total isolation of the patient from the familial influence and contact until a complete weight recovery has proven beneficial in the short-term. This goes without saying that in the long-term prospects of patient rehabilitation causes detrimental collateral effects which include that abandonment of treatment by the patient. As a result the Vanderecyken treatment initiative was modified to a therapeutic platform that places an emphasis on the involvement and needs of the family. Crisp & Coll., as an example, had documented an elevated psychoneurotic symptomatic development in fathers and mothers of anorexic patients. This is an accompanied observation that in some cases, an observed worsening of parental symptoms is progressively parallel to the improvement of the physical state of an anorexic patient [17].

The family and the crisis: intervention models

The modalities of services responsible for the care of patients struggling with psychological troubles cannot neglect how a patient's relationship with their family is a paramount pillar in the care project. On a separate note, the interactive experiences between the patient and the family develops the basis for the progression of the illness and its prognosis. During the intervals of crisis, patients seek familial reinforcement and support; its availability is a convenience to aid in the therapeutic process. On a contralateral occurrence, where there is an absence or conflict within the infrastructure of the family during a patient's crisis state, causes dramatic misconception or repulsion against the therapeutic choices that can weigh heavily on the patient even at times of good health, but also in a controlled psychological discomfort. A crisis is an intensified period in a patient's emotional dependency and identity, in this case, the family's presence acts as an instrument to preserve the patient's "historical" identity, and an elective speaker relating to the emotional relationships between the patient and family [2, 12, 18].

The schools of thought regarding the clinical studies of utilizing familial-intervention during the treatment process, has provided an avenue to construct supplementary models, where the family relationships and the interpersonal dynamics are taken into account. Eating disorders (EDs) have been treated by best practice methods where the family is a cornerstone in the rehabilitation of the adolescent patient. The family is now considered a central ingredient in the recovery of a patient with anorexia nervosa [19,20]. As far back as the 1970's the family involvement paradigm has been evaluated as part of the dynamic to influence the progression of anorexia nervosa; Salvador Minuchin, the founder of structural family therapy stated "Familial patterns of overprotectiveness, rigidity, enmeshment, and conflict avoidance were putatively addressed in part by restoring intergenerational boundaries and establishing effective conflict management" making him and his collegues the pioneers in providing the evidence that familial involvement during the treatment process is helpful for the adolescent patient [14].

An alternative view of the family treatment of adolescents with AN was developed around the same time in the family systemic therapy school in Milan, by Selvini Palazzoli. The therapeutic position in systemic family therapy is non-directive and promotes family exploration and autonomy in promoting change. The therapist joins the family in the role of supporting her, thus avoiding the family's resistance to external interventions. [15].

Other schools of family therapy have also contributed to the development of a specific adolescent family therapy model, including strategic family therapy and narrative family therapy.

These basic models provided the basis for what is now called Family-Based Treatment (FBT), developed at the Institute of Psychiatry, which combined structural, systemic, strategic, and narrative components of family therapy that are considered practical in the treatment of AN.

In FBT, a central fact states that no accountability or blame is targeted on the family for the adolescent's AN, but rather the family is a constructive resource to the child's AN recovery. At the core of FBT, parents are encouraged to manage behaviours that prolong AN (binge eating, purging, food restrictions, and prolonged excercise). Parents are empowered to become an authority figure to their child, and the therapist is a consulting body regarding the facets of AN. Modification in the family's role and hierarchy is applied in the presence of interference exhibited by their inability to support the child to gain weight [21].

Implementation of family-based treatment of eating disorders

A set of fundamental assumptions underlies all therapeutic interventions within FBT.

Principles of FBT for AN:

1. Agnosticism – decresing parental guilt and blame; facilitating focus on current maintaining features of the ED;
2. Symptom focus – disrupting behaviors that maintain ED;
3. Consultative therapeutic stance – increasing parental alignment and self-efficacy;
4. Parental empowerment - repositioning parents as authority on their child, increasing parental self-efficacy;
5. Externalization of illness – separating the illness from the patient; decreasing familial criticism; aligning with the healthy part of the adolescent [21].

FBT postulates that there is no known cause of AN, which is multifactorial, through the interaction of biological, social and psychological factors.

It is important that the family is not blamed for the onset of the disorder and that the therapists help the parents not to blame themselves. At the same time, AN is not under control of the adolescent.

As in disease models of mental illness, AN is initially seen as a medical condition and the severe somatic consequences must be treated. Thus, parents are empowered to treat their child, the medication being the food itself, to restore physical health and cognitive functioning.

As the health condition is restored, the adolescent's autonomy can be negotiated, the condition of the disease being externalized. Thus, while the family receives support in observing the behaviors and emotional and social consequences of the ED as belonging to the disease, it becomes better prepared to separate the disease from their child. In this way, control over the specific behaviors of the ED can be taken over, while promoting health and providing support. [11,21,22].

Treatment

FBT for AN typically lasts 10-20 sessions over 6-12 months. Shorter forms of FTB may also be effective, and recent data show that weight gain (around 2–2.5 kg [4–5 pounds]) is the most important indicator of recovery. [23,24]. Therefore, the main goal is to restore weight at home (monitoring growth curves, resumption of hormonal function and menstruation in girls), and the therapist will not engage in negotiations with the adolescent about weight gain. [21,22].

The first phase of the intervention focuses on parental empowerment, agnosticism and externalizing the illness, while the therapist monitors feedback on the progress of

nutritional rehabilitation, directs therapeutic discussions toward food and eating management, and supports parents in their adolescent recovery efforts.

As the patient with AN shows a more compliant attitude towards eating behavior, respecting the consumption of the necessary meals and accepting the refeeding efforts from his parents without conflict, the preparation for phase II will be considered. This stage does not begin until a sufficient increase in weight has been recorded (usually up to 90% -95% of the expected body weight) and it involves modeling an adequate independence for development, as well as gradually granting the adolescent autonomy in terms of nutrition.

Preparation to enter phase III is determined by achieving and maintaining a healthy weight, as well as regaining independence in terms of nutrition. At this stage, the therapist helps the family in focus on developmental challenges and family concerns, encouraging the family to extrapolate acquired skills to other non-ED challenges and establish a relapse prevention plan.

Empirical findings on family-based treatment of anorexia nervosa

Most empirical studies in AN in adolescents have included variants of FBT in its current iteration, and currently, clinical guidelines recommend family treatment as a first-line approach [19, 25]. Data suggests that family therapy may be especially beneficial for those with a shorter duration of the disease (<3 years) and onset before the age of 18 [26,27]. People who received FBT were less likely to need hospitalization and had lower recurrence rates at one year of follow-up. In the largest study to date, FBT has been compared with family system therapy (SyFT), with both groups achieving similar remission rates in ED symptoms, but FBT has promoted faster weight gain, required less hospital visits and was less expensive for the family than SyFT [28]. These preliminary findings provide strong support for the ongoing exploration of family therapy with this group and also suggest situations where methods need to be improved or adapted for patients who have not progressed [21].

FBT has been shown to be effective for adolescents with AN when administered in a shorter period (consisting of 10 sessions delivered in 6 months compared to 20 sessions delivered in 12 months); however, patients from disorganized families and those who are more obsessed with food and weight have benefited from the longer format. In the case of families where there is frequent criticism of the adolescent (high levels of emotion expressed [EE]), better results were obtained by consulting parents separately from their child [29]. In addition, FBT appears to be more successful in treating those individuals with higher eating-related obsessive-compulsive features than individual treatment. People with comorbid psychiatric illness also show lower rates of remission and abandonment in FBT [11,13,21,22].

DISCUSSIONS

The outcome in FBT for AN is measured by observing eating behavior, weight gain, nutritional rehabilitation and the resumption of physical health status, the main goal being complete weight recovery and return to premorbid growth and development. Complete remission is defined as reaching a weight of 95% of the expected body weight for age and height [30].]. It is also important to consider the pattern of growth prior to the onset of AN. Early weight gain (about 4-5 kilograms in the first month of treatment) is a good prognostic indicator of complete recovery at the end of treatment for adolescents with AN, along with the ability to maintain healthy eating patterns with parental supervision. In FBT, another goal is also psychological recovery (absence of ED cognitions). However,

these symptoms usually persist beyond weight recovery, usually returning to normal after about 1 year [31]. A recent observational study suggests that a certain behavior of the family during meals may influence the recovery process, requiring the adaptation of the therapeutic program or alternative methods of treatment [32]. However, at this time, there is little data to predict exactly who is more likely to benefit from FBT; thus, therapists must have good clinical judgment, assessing patient safety, symptom severity, and parental ability to determine when to follow alternative treatment models [21].

CONCLUSIONS

FBT is the best evidence-based treatment for adolescents with short-term AN. Although further studies are needed to improve understanding of FBT, to improve FBT response rates, and to identify alternative treatment for FBT, therapists working with this age group should be familiar with this approach. In the case of adolescent AN, parental involvement in the weight gain process with early weight gain appears to be critical and shows improved recovery rates compared to an individual approach designed to promote adolescent autonomy. It is imperative that therapists join patients and families if they want to make progress in raising awareness of eating disorders, increasing the availability of appropriate treatments, and encouraging research on eating disorders. On a final note regarding Anorexia Nervosa and the required treatment approach involving familial influence in creating the cobblestone path to help mentor, guide, motivate, and never deteriorate or subject to negative criticism the fragile cognitive and physical state of that the patient. The individual has placed themselves in a deep hole that seems to get darker and darker, but in establishing the proper protocols to set in motion centered on the value of the individual and their importance within the homeostasis of the family structure, while identifying their own state of identity and autonomy, will they finally realize their self-worth in their individuation.

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