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POSITION OF MULTI-FAMILY APPROACH IN THE THERAPY OF ADOLESCENTS WITH ANOREXIA NERVOSA. DESCRIPTION OF THE METHOD AND RESULTS OF CLINICAL STUDIES

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Summary

The authors, continuing to write about multifamily therapy (MFT), present the multifamily approach to the treatment of patients with eating disorders. This method of therapy, with simultaneous participation of several family systems that struggle with a disordered child, has been practiced since the 1980s but its intensive development occurred mostly in the last twenty years. The authors, drawing from several reports, point to the benefits of multifamily therapy as a method of treatment of anorexic teenagers. They present models of therapy that were utilized by different clinical teams and present the results of clinical studies. Multi-family therapy for teenagers with anorexia seems to be as effective as traditional family therapy. Its advantage is that it actively uses resources of the participants and creates the context for rapid growth in families. Due to insufficient data, the discussed method of work requires further research on its effectiveness. Authors recommend incorporating this approach to eating disorder treatment programs that are already existing in Poland.

Introduction

Anorexia nervosa is a disorder that leads to a significant deterioration of the patient's and his family's life. It is often a source of fear for the patient's life, causes uncertainty concerning future development of the illness and it frequently evokes feelings of helplessness which may lead to anger. These feelings affect not only the patient but as well their nearest environment and, moreover, also professionals who treat patients with eating disorders. These facts should not come as a surprise if one

bears in mind the fact that mortality rates in the discussed group of patients are the highest compared to populations of patients suffering from other mental disorders.

Anorexia nervosa is a relatively common condition. Epidemiological data coming from wide-scale population studies in Western Europe and the United States give figures of 0.9% in women and 0.3% in men [1]. To date, no similar population studies have been conducted in Poland in reference to mortality in patients suffering from anorexia. However, it is reasonable to assume that these figures in the Polish population will be comparable to those characterising other Western European countries and the US.

The authors of the therapy standards for eating disorders, published in Poland in 2008, stated that the majority of patients with diagnosed anorexia nervosa may be treated in the form of outpatient therapy [2]. According to these assumptions, the possibility of starting a therapy in the form of outpatient treatment is dependant on several factors such as: the patient's motivation, occurrence of other psychological disorders or severe complications of their somatic condition, and also the patient's BMI (whether it is not too low for outpatient treatment to be safe). Patients, in whose cases outpatient treatment is impossible due to the above reasons, are proposed to participate in inpatient treatment at a psychiatric ward. Hospitalization in a stationary ward is a good antidote for increased feelings of fear and insecurity that appear in members of the family and clinicians.

Additionally, scientific publications point to a sub-population of patients (even up to 10% of those who are treated in therapy centres of a higher referral level) in whose cases using the advised therapeutic strategies does not bring satisfying results – usually, they require frequent hospitalizations and a higher amount of therapeutic input [3].

In Poland, there are no specialized therapy centres within structures of the national health service that focus on complex therapy of adolescents with eating disorders. Their treatment in hospital conditions takes place mainly in general psychiatric wards for children and adolescents. Outpatient treatment is conducted chiefly by specialists – child and adolescent psychiatrists, psychotherapists, and family therapists. Some ambulatory care centres create separate subunits dedicated to the treatment of the discussed patient group – as an example may serve the Family Therapy Outpatient Unit at the University Hospital in Krakow.

Family Therapy in Treatment of Patients with Anorexia Nervosa

The key role of the family and its significance in the aetiology of eating disorders in children was already noticed in the 19th century [4]. Therapists practising psychoanalysis drew attention to the influence of family relations on the development of the disorders discussed in this paper. However, their omission of such family members as the father and siblings, and thus transferring the burden of responsibility to the mother figure, has met with widespread criticism [5].

Not long afterwards, Minuchin [6, 7] and Selvini C [8] noticed some distinguishing features in families that struggle with eating disorders of their children. These two researchers of family systems drew attention to very close relations between family members, lack of clearly defined boundaries between subsystems and tendencies to avoid conflicts. Minuchin's model of "the psychosomatic family" became one of the fundamental elements when attempting to understand patients with eating disorders. According to this theory, it was important to emphasise internal family interactions and their influence on the pathogenesis of anorexia, while resulting observations were supposed to aid in identifying the most suitable therapeutic strategies matching requirements of individual families.

According to the results of Minuchin's research, in cases of adolescents suffering from anorexia nervosa, who were treated mainly through family therapy, it was often possible to avoid hospitalization. At the end of therapy, 50-65% of patients achieved standard body mass, 60-90% completely recovered, while in 10-15% of cases the disease gained a chronic form [7].

At the end of the 1970s, a new paradigm for treating eating disorders was postulated at the Maudsley Hospital in London. It was based to a great extent on experiences of teams led by Minuchin and Palazzoli, yet it differed in the way of perceiving the family. According to the paradigm for treating patients with anorexia that was adopted at Maudsley, the family and dynamics of internal family relations ceased to be the main factor affected by the therapy. Instead, it became a potential source of introducing changes during therapy. Attention was drawn to the burden of guilt carried by the parents, therefore, it was decided that the family should be treated as an asset and resource, and not as a liability [4]. Currently, models explaining the aetiology of eating disorders in which the family is blamed for the development of the illness are not supported by therapeutic professionals.

With the passage of years, there was an increasing amount of reports confirming the effectiveness of family therapy in treating patients with eating disorders. Among others, results of clinical studies were published by researchers from the Maudsley Hospital [9-14], Children's Hospital of Michigan, USA [15, 16], and from other research centres. The beneficial influence of the family therapy in the treatment of patients with eating disorders was also indicated by authors of other publications and meta-analyses [17-19], while family therapy was accepted as a therapeutic method of choice in many official guidelines [20, 21].

Also in Poland, there has been a many years-long tradition of working with families that struggle with eating disorders of their children. Several teams of researchers and therapists have described family therapy as an independent therapeutic method or in combination with other treatments [2, 22, 23].

Multi-Family Therapy in the Treatment of Patients with Anorexia Nervosa

The first ideas to simultaneously involve several families in the therapeutic process appeared already in the 1960s and their first propagator was the psychiatrist Peter Laqueur, who currently is

considered to be the father of the multi-family therapy [24]. The method, which initially was used as a support treatment for psychotic patients (in combination with insulin shock therapy, which was popular at that time), with the passage of years started to be used in other contexts. The biggest contribution to this therapeutic method is owed to the British psychiatrist Eia Asen [25-27]. To date, the journal *Psychoterapia* has published two articles covering multi-family therapy – describing the creation and development of the method [28] and employment of this method in helping so-called "multi-problem" families [29].

A family in which there is an adolescent suffering from anorexia nervosa is often confronted with feelings of shame and guilt. Meal times – instead of being a pleasant pastime which strengthens family bonds – become filled with tension, antipathy, or even spite and aggression. Difficulties in the joint consumption of meals make it difficult to fulfil the socializing function of eating, which results in the family being reluctant to celebrate holiday meals in extensive company. On the other hand, the adolescent tends not to invite their friends home and rejects offers of spending time with peers outside home. Public appearances with an undernourished teenager may also be a source of shame and embarrassment. All these issues combined may lead with time to increased feelings of alienation and social isolation. Simultaneously, the family develops a conviction about its own helplessness and lack of hope for success. Meeting other families that are experiencing similar issues enables de-stigmatization and helps to mitigate the feeling of alienation, which is especially strong in families struggling with anorexia. A relatively small number of therapists during the sessions, first of all, creates a rather more "family-oriented" (in contrast to "medical") atmosphere, and secondly, gives an impression that the families themselves have sufficient resources to deal with the problem without outside help of professionals. This is especially important in the case of families whose adolescent has been admitted to a hospital ward, where they regained their body mass and then lost it again after leaving the hospital, which – according to the experience of many inpatient treatment centres – is quite a common phenomenon [9, 11, 30]. Such a train of events may lead parents to become convinced that they are inapt and need to be supported during treatment by institutions and professionals. Characteristically for this group, family members often tend to have a biased way of perceiving and thinking (*e.g.* what ingredients and what meal volumes are adequate, what body mass is healthy). However, they retain criticism and accurate intuitive assessment when judging behaviours and ways of thinking of other families. A meeting at a multi-family session is an opportunity to scrutinize problems from a variety of perspectives and learn from each other. Development of the multi-family therapy may bring many benefits, which is stressed both by therapists and by participants. These benefits have been compiled in Table 1.

Tab.1. **Indications justifying the introduction of multi-family therapy [modified after: 28]**

Creating the sensation of solidarity
Overcoming stigmatization and social isolation
Searching for new perspectives
Learning from each other
Being a reflection for others
Positively using group influence
Mutual support and providing feedback
Discovering and building new competencies
Experimenting with "foster" families and taking care of children from other families
Intensifying interaction and experiences
Giving hope
Testing new patterns of behaviour in a safe environment
Strengthening abilities of self-reflection
Encouraging openness and boosting self-confidence through a public exchange of experiences and interaction

The first reports on multi-family therapy applied to the treatment of patients with eating disorders were published in 1989. They came from the Slagerman-Yager team [31], who described their experiences gained during a multi-family therapy consisting of six sessions dedicated to families of patients suffering from anorexia or bulimia. The sessions were characterized by a high level of structuring – various techniques were used during them, including psychoeducation, home assignments, skill-developing training, and discussion groups. The families received this type of support very positively – though their members concluded that the programme (6 meetings) was definitely too short for their needs.

In 2000, two teams of researchers-therapists – the Scholz-Asen team from Dresden [26, 30, 32] and the Maudsley team led by Dare and Eisler from London [3, 33-35] – started using the therapeutic method discussed in this paper in families whose children suffered from anorexia nervosa. Both therapeutic centres implemented programmes of the multi-family therapy based on a paradigm for treating patients with anorexia which was created at Maudsley and whose leading idea was to support through the therapeutic process those families which did not improve after the family therapy that had been conducted individually [3, 36, 37]. At the same time, the teams were inspired by publications of Eia Asen, who used multi-family therapy at the Malborough Day Hospital in London with big successes as part of "day-care ward for multi-problem families" [27, 38]. As a result, both teams decided to conduct therapy in the setting of day-care clinics. The method of work that was developed by both teams was a combination of their own experience in treating patients suffering from eating disorders with theoretical assumptions of Asen's multi-family day-care therapy.

At the same time, in France [39] and the UK [40], another form of the multi-family therapy for eating disorders started to be developed – it was also based on a structural approach, nevertheless, it was not as "structurally-oriented" as in the case of the Maudsley model. It appears that the multi-family therapy for eating disorders was being developed in Europe according to three distinctive models (which will be partly discussed in this paper): the Maudsley paradigm, the classical systemic paradigm, and the psychoeducational model [41].

Experiences of the Dresden Team

Experiences of the Dresden team were described in a series of original articles published by Michael Scholz [30, 32]. The project of implementing multi-family therapy into the therapeutic offer of the centre was initiated in 1998. Experiments were conducted in order to establish the optimal number of days dedicated to the therapy. The considered options included 5 consecutive working days, one whole weekend or a single full day repeated every 3 weeks for a period of 6 months. Eventually, it was decided that the therapeutic programme would consist of a few blocks amounting in total to 20 treatment days and spread across a period of one year. In the Dresden treatment programme, the therapy commenced with a 5-day block, then – after a 3-week break – there was another 3-day block, and afterwards, families met in 2-day blocks once a month, while in the last phase of the therapy, meetings took place once a month. An example of a day timetable developed by the Dresden team may be seen in Table 2.

Tab.2. **Model day timetable (modified after [7])**

8.45 am	Measuring body mass of each patient (eating and body mass should become key issues of the therapy)
9.00 am	Introductory talk and group discussions (presenting principles of multi-family therapy, reasons for organizing meetings of a few families simultaneously, elements of psycho-education)
9.30 am	Group breakfast (observing behavioural patterns of families during meals)
10.00 am	Artistic workshops (manual activities relating to the self-image of one's body and attitudes to eating)
11.15 am	Group reflection (presenting by families the effects of their art workshops and providing feedback from other families)
12.30 pm	Group lunch (crucial point of the programme, attempt at changing *in vivo* problematic relations between patient and family)
1.15 pm	Free time (informal time for families – to be spent on casual conversations and getting to know each other)
1.45 pm	Therapeutic session using the video-feedback technique (playing on screen key moments and situations that were filmed during the whole day, participants share comments)
3.00 pm	Group reflection (discussions about therapeutic work completed during the day)
4.30 pm	Tea and closing (another opportunity for families to have chats and arrange meetings outside the programme)

Initially, the team introduced multi-family treatment techniques as complementary to other forms of therapy. In cases of patients without severe symptoms of anorexia nervosa, the team used family therapy and individual psychotherapy of identified patients, conducted in the form of outpatient treatment,

while in cases of more seriously ill patients, inpatient treatment was employed. The following criteria for admitting a patient to inpatient treatment were considered: fast loss of body mass despite an initiated outpatient therapy, BMI lower than 15, bradycardia, increased symptoms of depression, and self-harm episodes. Due to its higher referral level, the centre mainly received patients with a severe history of the disorder. As part of a patient's stay in the centre, patients participated in numerous forms of treatments, including behavioural interventions, individual psychotherapy in a psychodynamic or a cognitive paradigm, and also – routinely in the case of all patients – there were several sessions of family therapy at 2-week intervals. After a standard body mass was regained, the hospitalization period would finish; its average time span was around 12 weeks. After discharging, patients were recommended for further outpatient treatment, which was based on individual psychotherapy and family therapy.

In 2003, the team participated in a multi-centre study evaluating the effectiveness of various forms of treatment (individual therapy *vs* family therapy *vs* multi-family therapy) and, as a consequence, the Dresden centre started qualifying patients for separate non-combined forms of treatment, which translated into conducting treatments of families and patients in a singular modality (which meant for example that seriously ill patients were treated only by means of multi-family therapy without a simultaneous hospitalization in a psychiatric ward). The team involved in the therapy of each patient group consisted of two nurses, a psychologist, a social worker, a psychiatrist and an occupational therapist – the roles assigned to the team members were varied (therapeutic work/observation/consultation/supervision).

The treatment, as part of the multi-family therapy, commenced with a conversation with the family about methods and forms of therapeutic work, therapeutic goals, and assessment of the family's motivation for participation in the programme. During the first interview, the family was invited to an introductory meeting (a so-called "tasting evening"), which was also attended by members of families that had already completed their multi-family therapy (they acted as "ambassadors" or "experts through experience"). In the experience of the Dresden team, the role of this meeting was to convince families with a more sceptical attitude towards participation in the proposed model of therapeutic work.

The first phase of the treatment, according to the Dresden model, focused mainly on manifesting and enhancing the roles of parents in successful coping with non-adaptive behaviours of their child. Parents were encouraged to be more persistent and consequent in introducing a nutrition plan and more successful in the employment of resources and development of their skills. Parents were informed that it was mainly their responsibility (and not that of the staff) to exert influence over their children and motivate them for changes, which meant they needed to establish adequate boundaries and not get involved in ineffective negotiations concerning nutrition. Therapists avoided taking over tasks from parents and in this context did not model appropriate behaviour. In this phase of therapy, the main part of therapeutic work happened during meals when problematic family relations and communicative patterns became more manifested. Resources of other parents were employed at such moments, taking advantage

of new perspectives and behaviours (*e.g.* through asking parents from one family to assist during a meal of a patient from another family).

In the second phase, the therapy took a different direction and gradually departed from topics associated with nutrition in order to focus on internal family relations (*e.g.* family hierarchy, alliances and coalitions, "family secrets", family-specific disturbances of communication, inadequate emotional involvements, high level of criticism). In this phase of therapy, parents were encouraged to search for methods to manage emotional difficulties caused by their child's illness. Insights also included parents' own systems of values and aspirations.

The third phase of the treatment concentrated on discussing issues enabling prevention of relapses – *e.g.* early detection of the symptoms. Work within this phase also concerned the adolescent's autonomy, especially with respect to issues relating to nutrition and body.

Although the first phase of the therapy was mainly centred around Minuchin's ideas of structural family therapy, during the second and third phase, therapists freely took advantage of ideas practices by the Milan team, therapists of the narrative approach, and solution-focused therapy.

According to the Dresden team, the only actual contraindication for participation in the multi-family therapy were acute psychotic disorders, severe depressive disorders or intellectual disability of a family member. The therapists also did not decide to qualify for the treatment families in which there were instances of domestic violence or other forms of abuse, and also families in which conflicts were so intense that family members could not bear staying together in the same room.

Experiences of the London Team

In 2000, London therapists – Christopher Dare and Ivan Eisler [3] – described multi-family therapy as a new form of therapeutic influence in treating eating disorders. Quoting numerous reports [10, 14, 15], they stated that family psychotherapy is an important element of work with adolescents suffering from anorexia. Moreover, they contributed their vast experience in treating a great number of patients for whom outpatient treatment proved to be insufficient. Therefore, they proposed to intensify the treatment through multi-family meetings, which would unify the strengths of several families and thus maximize the amount of experiences, perspectives, and opportunities for mutual support of participants.

All patients and their parents, invited to participate in the therapy, were initially asked to attend a meeting which focused on medical and psychiatric elements of the patient's medical condition in order to establish a diagnosis and the type of disorder that they struggled with. There was also a moment when families were asked to describe their previous therapeutic experiences, express their opinions concerning sources and nature of the disease, and also their expectations concerning the therapy. This initial interview allowed the therapists to invite the families to another multi-family therapeutic meeting or to initiate other therapeutic strategies, adjusted to the needs of the patient and their family. The authors

proposed a 24-week programme with a precisely defined schedule. The first week of treatment started with 4 days of therapy from 9:00 am to 5:00 pm. In the next week, families met for a single full day. Then, the frequency of the meetings was decreased to once a month, while in the meantime, therapists conducted individual meetings for families that required them. Later, therapeutic meetings lasted for half a day. The first two meetings (at 4-week intervals, and later at 6-week intervals) started at 1:00 pm to allow families to have a group meal together. Afterwards, during a one-year period, families had the opportunity to participate individually in sessions in order to continue the therapeutic process. All members of the family who felt involved were invited to participate in the programme, including divorced parents or siblings that had left the family home. Siblings were excluded only from the first meeting of the multi-family therapy. However, during the remaining time of the therapy, relations between siblings became a crucial area of work. The majority of the programme included verbal therapeutic techniques – *i.e.* psychoeducation, family therapy, group therapy – which were intertwined with multi-family meetings (sometimes adolescents and adults met separately) and individual meetings. In the programme, there was place for joint preparation and consumption of group meals, and also free discussions which revolved around methods of dealing by parents with their anxiety related to eating and regaining standard body weight by their children [3, 35].

Belgian-French Experiences

In her publication from 2016 [42], Zoe Gelin presents in a very transparent way two models of the multi-family therapy that are prevalent in Belgium and France. The first presented model was inspired and oriented similarly to the above examples described in this paper, which means that it was based on principles developed at Maudsley. The second one is an integration of a model based on systemic concepts – it combines ideas about eating disorders and internal/external family relations. The latter model was developed in 1990 as a therapy method for eating disorders in children and adolescents at the Robert Debre Hospital in Paris [39, 42]. Initially, traditional family therapy was used at the hospital, but later, in 2000, multi-family therapy was added to therapeutic methods, targeting specific needs of families that did not benefit sufficiently from a single-family therapy in which the ill adolescent/child experienced repetitive hospitalizations or when their outpatient treatment failed. The systemic paradigm in this case focused on three vital areas: 1) observing psychological symptoms within the social context of the patient, 2) involving all family members in the therapeutic process, 3) noticing problems, their sources, and preferential solutions from the patient's point of view.

Effectiveness of Multi-Family Therapy in Treating Adolescent Patients with Anorexia Nervosa

Up to the present, reports on the effectiveness of the multi-family therapy have come from single open non-randomized clinical trials. Authors of the research projects reported about improvements in

patients' body mass and eating habits, motivation for recovery, mood and self-esteem, quality of life, increased self-belief of parents in their abilities [12, 32, 34, 43-46], and a lowered number of hospitalizations and their average time span [30, 43]. A low percentage of therapy dropouts was reported, while the positive feedback from families indicated a high level of satisfaction from the treatment [3, 30].

To date, there has been only a single multi-centre trial with randomization [35] on the effectiveness of multi-family therapy compared to traditional family therapy. A second trial of this sort is to be conducted in France and its research protocol was published a few months ago [47]. The conclusion of the completed randomized trial in London was an observation that multi-family therapy is as effective as traditional family therapy, while in some aspects it even brought more benefits (*e.g.* after a year under observation, patients randomly selected for the multi-family therapy more frequently received on average categories "good" or "intermediate" according to the Morgana-Russel scale, which assesses syndrome intensity of eating disorders).

Conclusions

Systemic thinking and family therapy have a long tradition in treating patients with eating disorders. This fact is reflected by scientific publications and treatment standards, whose authors recommend using family therapy as a first-choice treatment. The multi-family therapy, being a hybrid of family and group therapies, is a relatively recently introduced form of therapeutic work, which allows for intensification of therapeutic actions and saving resources necessary for the treatment. This fact, in the face of changing circumstances – *i.e.* a constantly increasing demand from patients and their families for therapy and a simultaneous decrease of available resources (therapists fleeing to the private sector, insufficient resources for children's and adolescent psychiatry and family therapy in Poland), may be worth taking into consideration when making a decision about employing adequate therapeutic methods for treating adolescents with anorexia nervosa. We hope that in the future, conducting multi-family therapy in Poland not only will be possible but also common and wide-spread.

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