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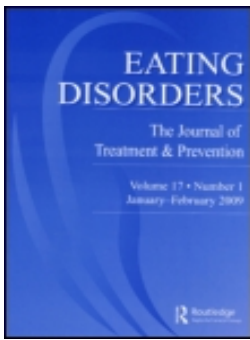
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Adapting Family-Based Treatment for Adolescent Anorexia Nervosa Across Higher Levels of Patient Care

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An increasing body of evidence supports the use of family-based treatment (FBT) in medically stable outpatient presentations of adolescent anorexia nervosa, although there is relatively less research on adapting evidence-based treatment approaches in more intensive levels of patient care. The integration of FBT, which centrally leverages parental involvement in more intensive levels of care which typically require greater clinical management, requires careful consideration. We provide an overview of several key practical and theoretical considerations when adjusting the delivery of FBT across more intensive levels of patient care, providing clinical guidelines for the delivery of FBT while ensuring fidelity to the core theoretical tenets. Implications for clinical practice and future research are discussed.

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Anorexia nervosa (AN) typically demonstrates poor treatment outcomes, high rates of relapse and treatment drop-out (Keel & Brown, 2010), elevated rates of premature death related to both medical complications (Steinhausen, 2002) and suicidality (Pompili, Mancinelli, Girardi, Ruberto, & Tatarelli, 2004), and reduced quality of life (Mond, Hay, Rodgers, Owen, & Beumont, 2005). However, when treated during adolescence, favorable treatment outcomes appear somewhat more attainable (Treasure & Russell, 2011). Thus, recent efforts have focused on treatments targeted at adolescent presentations, with family-based treatment (FBT) showing particular promise (Lock & Le Grange, 2013). However, while efforts to disseminate FBT have largely focused on outpatient settings (Couturier, Kimber, & Szatmari, 2013), there is a dearth of evidence detailing the application of FBT to more intensive levels of patient care.

AN is typically treated across a range of treatment contexts based on illness severity, with some arguing that presentations of AN ought to be delineated by stages of severity in order to allow for the most effective and appropriate treatment (Maguire et al., 2009). Indeed, the continuum of care model ensures that treatment dosage can be matched with illness severity, while significantly reducing the overall cost of treatment (Kaye, Enright, & Lesser, 1998; Wiseman, Sunday, Klapper, Harris, & Halmi, 2001).

A patient's transition through levels of care is typically determined by symptom severity, medical status, motivational status, treatment history, and logistical concerns, although with fluctuating levels of motivation for change (Geller, Zaitsoff, & Srikameswaran, 2005) and relapsing symptom severity (Strober, Freeman, & Morell, 1997), movement through the levels of care can be bidirectional. The significance of this multi-tiered level of care system is underscored when considering (a) the medically necessary need for urgent weight restoration in severe AN, (b) the management of clinical complexity and comorbidity, and (c) the need to ensure progress sustainability in the context of the high rates of relapse in AN (Strober et al., 1997). However, few treatment settings currently offer all levels of care within the same setting, and the integration of evidence-based treatment throughout varying levels of care in the treatment of AN poses many challenges. This may be particularly important as it pertains to the role of families in treatment, given the differing beliefs as to the optimal role of families in the treatment of adolescent AN (Le Grange, Lock, Loeb, & Nicholls, 2010; Murray, Thornton, & Wallis, 2012a).

FBT is characterized by an agnostic stance towards the origin of AN and a conceptualization of parents as the primary resource in restoring their adolescent back to health. The focus of the treatment is orchestrating a parent-driven intervention to restore healthy eating patterns in the adolescent and then gradually transitioning the adolescent back to eating autonomy (Lock & Le Grange, 2013). Empirical evidence suggests that 50–70% of adolescents with AN undergoing FBT are weight restored within a year of

commencing treatment, and up to 40% being remitted of cognitive symptomatology (Lock et al., 2010). Follow-up studies and meta-analyses further support the efficacy of FBT, suggesting robust symptom remission over time (Couturier et al., 2013; Eisler, Simic, Russell, & Dare, 2007).

THE APPLICATION OF FAMILY-BASED TREATMENT ACROSS THE CONTINUUM OF CARE

The lack of clinical research on the efficacy and feasibility of FBT across the continuum of care is particularly important when considering (a) the volume of adolescents with AN who require non-outpatient based treatment at some stage of their treatment trajectory (Katzman, 2005), and (b) recent findings underscoring the importance of theoretical consistency across treatment providers and levels of care (Murray et al., 2012a; Murray, Griffiths, & Le Grange, 2014). With recent findings documenting that (a) rapid intervention and early treatment mechanisms are indicative of overall treatment outcome (Doyle, Le Grange, Loeb, Doyle, & Crosby, 2010; Le Grange, Accurso, Lock, Agras, & Bryson, 2014), and (b) those with more severe AN psychopathology typically report greater benefit from FBT than those with less marked symptomatology (Le Grange, Lock, Agras, Bryson, & Kraemer, 2012), there appears to be a clear rationale for applying FBT to intensive treatment settings.

However, there are many challenges inherent in practicing FBT across levels of care while maintaining treatment fidelity. Given that higher levels of patient care warrant greater professional involvement, there is a risk of undermining the FBT treatment approach which centralizes parental involvement and decentralizes professional expertise. Indeed, while current clinical practice has advocated the use of FBT in higher levels of care (e.g., Girz, LaFrance Robinson, Foroughe, Jasper, & Boachie, 2013; Henderson et al., 2014; Hoste, 2015), little theoretical guidance exists in its application. We therefore aim to outline a theoretical framework of how FBT may be applied across higher levels of patient care, outlining several key challenges and explicating how the theoretical underpinning of FBT may be applied in a way that ensures treatment fidelity.

Establishing the Role of Parents and the Treatment Team Throughout the Continuum of Care

The central premise of FBT posits that parents ought to be the central architects of their child's recovery, providing a sustainable agent of change which persists beyond any treatment context (Lock & Le Grange, 2013). However, higher levels of care are typically characterized by reduced

parental involvement in treatment, despite emerging evidence demonstrating that mechanisms of symptom remission in FBT appear to be driven by empowering parents to take control of their child's eating (Ellison et al., 2012). Thus, any adaptation of FBT to more intensive levels of patient care ought to carefully consider the dialectic of balancing the empowerment of parents while also ensuring thorough clinical management of medical instability.

Clinical Options

Restoring medical stability, offering respite for parents, and delaying the onset of FBT. The clinical reality in inpatient hospital settings is that urgent medical stabilization and caloric restoration take full priority. To this end, strict medical guidelines exist in expediently and safely curtailing the potential scope for medical complications in AN (Katzman, Peebles, Sawyer, Lock, & Le Grange, 2013). In this context, the time required in mobilizing disempowered parents into active symptom resolution may likely contravene medical best practice, which urges the most immediate restoration of medical stability. Thus, greater illness severity often necessitates swift medical intervention at the expense of parent-driven symptom reduction.

However, a key distinction was recently drawn between hospital-based medical stabilization and hospital-based weight restoration, with current evidence supporting inpatient medical stabilization and an expedient step-down into less intensive levels of care and parent-assisted weight restoration (Madden et al., 2014). Thus, *inpatient hospital settings* might be most suited to the urgent medical stabilization of acute AN that might preclude full parent involvement, followed by the commencement of FBT once the adolescent is medically stable and parents may play a more central role in treatment. However, with emerging evidence supporting shorter periods of inpatient hospitalization for adolescents with AN and swifter transitions into FBT (Madden et al., 2014), it is important to caution against offering respite for parents beyond a point when they could feasibly be involved in the feeding of their child. Indeed, parental respite beyond this point may alleviate the necessity for swift parental intervention, undermining subsequent treatment (Madden et al., 2014).

Increasing parental involvement as adolescents progress through levels of care. While keeping in mind the medical gravity of severe AN, exploring creative ways to involve the family as much as possible, even at higher levels of care, may be particularly congruent with FBT.

Inpatient hospital settings. While inpatient settings are necessarily oriented towards urgent medical stabilization, these settings are also uniquely placed to orient families towards the early goals of FBT. For instance, FBT clinicians may work alongside medical teams in: (a) raising parental anxiety which will further mobilize parental resources once FBT commences, and

(b) working to create unity between the parents. Concurrently, the medical team may assume the role as expert on the patient's medical status and communicate that information to the parents, further assisting in generating parental anxiety. Similarly, while dietitian involvement is not typically prescribed in outpatient FBT, the imminent weight gain requirements in critically unwell adolescents, coupled with the risk of re-feeding syndrome, may necessitate dietitian involvement. However, it is plausible to integrate parental involvement within the context of dietetic assistance, for instance, by having dietitians convey the calculated caloric requirements and consulting with parents as to how these calories are provided (Katzman et al., 2013).

Residential settings. A feature of residential programs is the temporary removal of adolescents from their home until symptom remission is indicated, which may impinge upon the prescribed and empirically supported role of parents throughout FBT (Ellison et al., 2012). As such, FBT in residential contexts may be inherently challenging, particularly when residential settings are not in the same geographical region as the family home. Endeavors towards this end may include encouraging parents' temporarily residing in the local area, including regular family meetings, the co-construction of treatment goals, and multiple family meals and parent coaching.

Patient hospitalization program/intensive outpatient program settings. Perhaps more amenable to an FBT framework, patient hospitalization program (PHP) and intensive outpatient program settings (IOP) settings feature day-based clinical treatment, coupled with home-based symptom management outside of program hours. Such settings allow for treatment goals to be oriented towards family psychoeducation and weight restoration in a manner consistent with outpatient FBT, although at a more intensive treatment dose and with more stringent medical monitoring. With respect to the broader treatment team, the physician (typically a pediatrician or psychiatrist), may not necessarily occupy the most central role at this level unless there are imminent medical concerns, instead serving as a consultant to the parents and FBT clinician while monitoring medical status (Katzman et al., 2013). Similarly, dietetic involvement may be downwardly adjusted in conjunction with increasing parental involvement over meal provision. For instance, dietitians at this level of care may serve primarily as a consultant to the family therapist as needed, especially in cases with complicated dietary features (e.g., diabetes, celiac disease, etc.), or in cases in which treatment is not progressing as expected (e.g., weight gain is not occurring, despite the family appearing to appropriately manage their child's behaviors). Furthermore, since patients in PHP/IOP typically attend most meals in program without the support of siblings, an individual therapist might play a role in a PHP/IOP setting by supporting the patient in the same way siblings are encouraged to support the patient in outpatient FBT. Additionally, due to the high level

of psychiatric comorbidities in higher levels of care, the individual therapist may concurrently provide other types of evidence-based treatment to address these issues.

MOBILIZING AND EMPOWERING PARENTS THROUGHOUT TREATMENT IN HOSPITAL AND PARTIAL HOSPITAL SETTINGS

Prior to beginning treatment, it is commonplace for many families to feel disempowered and ambivalent about the challenge of weight restoring their child with AN. Indeed, many families report inadvertently accommodating an array of AN-type behaviors in an attempt to allay their child's anxiety (Eisler, 2005). Thus, a crucial tenet of FBT posits that parents ought to be immediately ushered beyond any anxiety or avoidance and charged with the responsibility of urgent intervention of their child's behaviors.

To this end, a therapeutic "double-bind" at the outset of FBT aims to simultaneously elevate parental anxiety and implore parental intervention in reversing their child's symptoms (Dare et al., 1995; Lock & Le Grange, 2013). This is accomplished through a somber discussion of the medical complications of AN, which aims to render the anxiety parents feel about *not* confronting their child's AN greater than any anxiety around confronting their child's symptoms.

However, the timing of this therapeutic double-bind may need adaptation for clinical settings which foster greater staff than parental involvement and thus afford less scope for parental responsibility in symptom reduction. Raising parental anxiety and imploring their intervention in these settings may contraindicate the empowerment FBT advocates. For instance, it is possible that elevated parental anxiety at the outset of treatment may be more allayed by the child's involvement with the intensive staff-driven program than by their own increasing sense of mastery in managing their child's symptoms. In this respect, therapeutically elevating parental anxiety, when coupled with reduced scope for parental involvement and staff-driven reductions in parental anxiety, may potentially deepen a sense of reliance on staff-driven symptom reduction, which contravenes the mechanism by which the therapeutic double-bind was intended to operate in outpatient settings. Thus it is important that this double-bind at higher levels of care is carefully planned.

Clinical Options

Create greater scope for parental involvement in hospital and partial hospital settings. Many schools of family therapy posit that the most effective time to mobilize familial anxiety is during the peak of the most intense crisis (Haley, 1980), which for some families facing AN, will inevitably fall during

admissions to higher levels of care. However, FBT theory would posit that raising parental anxiety and empowerment ought to coincide with opportunity for parents to act on their raised anxiety and empowerment in curtailing their child's symptoms (Lock & Le Grange, 2013). To this end, one recently developed "family admissions program" involved entire families undergoing a 2-week inpatient hospital admission alongside their child with AN, both underscoring the magnitude of the family crisis and simultaneously allowing enhanced scope for parental involvement in symptom reduction (Wallis et al., 2013). Another program, operating at a PHP level, involved 40 hours of intensive FBT-based treatment over 1 week, allowing parents full scope for involvement at every meal, as well as intensive training on implementing FBT at home (Rockwell, Boutelle, Trunko, Jacobs, & Kaye, 2011). These approaches are predicated on both the theoretical notion and empirical findings stipulating that parental empowerment and influence over symptom reduction is most centrally connected to favorable long-term treatment outcome (Ellison et al., 2012). However, it should be noted that this approach is both time and labor intensive, meaning that very few families may be accommodated at any one time. In treatment settings, this may raise questions as to the practical viability of this approach, given that multiple adolescents typically require medical stabilization in specialized eating disorder units at any given time.

Coordinate several parental anxiety mobilizing meetings, geared towards specific stages of treatment in hospital and partial hospital settings. An alternative approach may integrate multiple staggered and specifically nuanced crisis meetings with parents at different levels of care, given the importance of not imploring parental involvement beyond what a particular treatment setting can accommodate. For instance, in attending to the most significant crisis around medical instability and urgent hospitalization, FBT clinicians may raise and mobilize anxiety with the goal of having parents commit to urgent hospitalization. In transitioning to a lower level of care, empirical findings suggest that many adolescents with AN do not consistently attend treatment or complete treatment of their own accord (Girz et al., 2013). Thus, the transition to this level of care may be punctuated by a more nuanced therapeutic double-bind in which parental anxiety is raised by being made aware of the relapse rates to hospital settings following hospital-driven weight restoration and the propensity for treatment dropout in partial hospital settings (Girz et al., 2013), mobilizing parents into a more active stance in ensuring continued treatment attendance and compliance as the child progresses through the levels of care.

Similarly, the transition to outpatient FBT, which is characterized by the greatest scope for parental involvement, may be marked by a further and qualitatively different therapeutic double-bind, which may place greater emphasis on parents in ensuring long-term symptom remission. Indeed, repeated "double-bind" sessions are common throughout FBT, either in

re-mobilizing parental resources in instances of treatment plateaus, or in priming parental resources for the next stage of treatment without endorsing parental complacency (Lock & Le Grange, 2013).

INDICES OF PARENTAL EFFICACY THROUGHOUT TREATMENT

The assessment of parental efficacy forms a crucial component of FBT and perhaps the most pivotal barometer of parental efficacy is their child's weight status, which affords direct feedback as to how effective parental efforts at weight restoration have been (Lock & Le Grange, 2013). This feedback is so important that it typically determines the content of every family meeting during the refeeding phase of outpatient FBT (Lock & Le Grange, 2013), with weight gain resulting in a family discussion amplifying parental strengths, and weight loss resulting in a discussion on the barriers which prevented weight gain (Murray, Wallis, & Rhodes, 2012b). Empirically, the role of adolescent weight status is so centrally implicated in outpatient FBT, that this is thought to be the primary criterion around which overall treatment response versus treatment non-response can be indicated during the early stages of treatment (Doyle et al., 2010; Le Grange et al., 2014).

However, in a higher level of care, it is likely that an adolescent's weight status may be impacted by a multitude of factors external to parental influence, including nasogastric feeding and carefully calculated clinic-based meal programs. Furthermore, failure to gain weight in such settings may be less common, which may further obscure the weight-based indexing of parental efficacy throughout the refeeding phase of treatment. Thus, alternative methods of indexing parental efficacy may be more appropriate in informing the content of family meetings in hospital and partial hospital settings.

Clinical Options

Indexing parental efficacy through weight-related data. Unless inpatient hospital settings are able to accommodate full-scale parental involvement, it is unlikely that early weight gain in such settings exclusively indicates parental efficacy. However, as adolescents progress into partial hospital settings, once medical instability subsides, weight-related data may be utilized creatively to indicate preliminary parental efficacy. In these settings, the adolescent spending weekends in their family home may allow for access to how weight change over weekends compares with weight change during weekdays, offering an insight as to how home-based weight restoration compares to in-program weight restoration. Access to these data may be crucial in accessing early indicants of parental efficacy, which may be utilized therapeutically in mobilizing parental anxiety and troubleshooting the parents' efforts to restore healthy eating in their child.

Developing alternate methods of indexing parental efficacy in hospital and partial hospital settings. When family involvement in hospital and partial hospital settings is not possible, alternate methods of indexing parental efficacy may be necessary. For instance, in instances when adolescents still require urgent and medically indicated weight restoration, a series of family meals may be employed by FBT therapists within hospital settings, affording an opportunity to assess parental efficacy around re-feeding. Clinical observations of the extent to which parents are able to effectively influence their child's eating behaviors, may be utilized to indicate parental efficacy and inform treatment content within hospital and partial hospital contexts.

MEAL PROVISION AND SUPERVISION THROUGHOUT TREATMENT

Predicated on the notion that symptomatic adolescents are almost exclusively making decisions that are influenced by the eating disorder, FBT is characterized by the removal of food-based choices from the adolescent, alongside intensive meal supervision. Wherever possible, the overseeing of food-based decisions and supervision of meals ought to be undertaken by parents, who typically have the greatest knowledge, authority over their dependent child, and scope for long-term symptom remission. Empirical evidence illustrates that, in fact, parental control over their child's AN symptom profile is the central predictor of favorable treatment outcome in those undergoing FBT for AN (Ellison et al., 2012). However, the provision and supervision of meals in hospital and partial hospital settings is most typically undertaken by staff, leading to the potential disparity between the agent of authority in home-based meals and program-based meals. Although a higher level of care could be used to offer respite for parents until the child discharges, with staff devising, serving and supervising all meals based on dietetic calculation and providing psychological support, that may miss a critically important window to build parents' skills and efficacy around re-feeding.

Clinical Options

Create the scope for parents to prepare, serve and supervise all program-based meals. Perhaps the closest approximation to standard FBT in hospital and partial hospital settings would involve full-scale parental involvement in meal preparation and supervision within hospital contexts. Practically, this may mean that parents would be present for all meal-based decision making, preparation, and supervision, as well as the supervision of any compensatory behaviors. However, adopting this approach in inpatient settings when urgent medical stabilization is required may impinge upon the rate of weight

restoration, potentially contravening medical best practice when urgent nutritional rehabilitation is required. Furthermore, a practical concern in higher levels of care may relate to the necessary structural and time constraints. For instance, idiosyncratic family meal preparation and supervision, several times per day, of differing lengths and emotional intensity, may render a structured treatment program comprising scheduled group and individual meetings with treatment specialists extremely challenging. As such, alternate provisions for integrating parental input around food-based decision making and meal supervision may be required.

Empower parents into a decision-making process. Empower parents into a decision-making process in terms of what food is served to their child in program-based meals, and how staff may assist their child, while taking into account the practical considerations of the treatment setting.

When full-scale family involvement during the meal provision and supervision process is not feasible, creative deviation from the manualized protocol may be required in ensuring therapeutic fidelity. For instance, one alternative to parents preparing and supervising all meals in hospital and partial hospital settings may involve parents preparing and bringing in their child's food for the day at the start of each day, allowing for individually tailored parent-devised dietary regimens without disrupting program feasibility. Whenever possible, allowing parents to individually tailor meals would allow for a greater inclusion of parental expertise, in addition to enhancing the ecological and cultural validity of the food consumed during treatment.

Further integration of parents into meal provision and supervision processes could involve staff calling on parents to assist staff with in-program meal supervision. In the event of challenging meals, FBT clinicians may seek guidance from parents as to which strategies might be most effective in supervising their child's meal. This would underscore the notion that parents themselves are ultimately responsible for refeeding their child, and may also be used to strategically orient parents towards the main tenets of treatment. For instance, consulting with parents directly as to how to be firm without being punitive towards their child during meals may prime parental focus on these areas for home-based meals, provoking reflection on their own use of these strategies. Furthermore, multifamily therapy theory posits that a large component of parental empowerment is garnered from the act of giving other families advice, crystallizing their own sense of agency (Murray & Le Grange, 2014). As such, it is likely that the act of guiding staff on how to coax their child through challenging meals could help parents develop a sense of efficacy, and further underscore the notion that the overall responsibility and expertise rests with parents. Staff could also call the parents to have them coach their child if meals are refused while in program. In those instances, parents could take over coaching the child by phone, or even come in and sit with their child to ensure meal compliance.

CONCLUSION

There can be little doubt surrounding the necessity for intensive levels of patient care in acute and severe presentations of adolescent AN, and the adaptation of FBT from outpatient to these settings may prove to be important in ensuring swift and lasting symptom remission. Indeed, with recent research suggesting that an expedited transition from inpatient care through to outpatient FBT is both cost-effective and clinically recommended (Madden et al., 2014), and that consistency between treatment providers across levels of care significantly relates to FBT outcome (Murray & Le Grange, 2014), the adaptation of FBT across treatment settings is warranted. We have aimed to outline theoretical and practical considerations in assisting clinicians across levels of care in determining the optimal balance between swift and staff-assisted symptom resolution in emergency situations, versus parent-driven symptom resolution in less critically unstable situations. However, it should be noted that the recommendations outlined are theoretical in nature, and it is critical that future research evaluate the efficacy of FBT across higher levels of care, as it remains unclear to what extent findings drawn from outpatient settings may translate into more intensive treatment settings.

REFERENCES

- Couturier, J., Kimber, M., & Szatmari, P. (2013). Efficacy of family-based treatment for adolescents with eating disorders: A systematic review and meta-analysis. *International Journal of Eating Disorders, 46*, 3–11.
- Dare, C., Eisler, I., Colahan, M., Crowther, C., Senior, R., & Asen, E. (1995). The listening heart and the Chi square: Clinical and empirical perceptions in the family therapy of anorexia nervosa. *Journal of Family Therapy, 17*, 19–45.
- Doyle, P. M., Le Grange, D., Loeb, K. L., Doyle, A. M., & Crosby, R. D. (2010). Early response to family-based treatment for adolescent anorexia nervosa. *International Journal of Eating Disorders, 43*, 659–662.
- Eisler, I. (2005). The empirical and theoretical base of family therapy and multiple family day therapy for adolescent anorexia nervosa. *Journal of Family Therapy, 27*, 104–131.
- Eisler, I., Simic, M., Russell, G. F. M., & Dare, C. (2007). A randomised controlled treatment trial of two forms of family therapy in adolescent anorexia nervosa: A five-year follow-up. *The Journal of Child Psychology and Psychiatry, 48*, 552–560.
- Ellison, R., Rhodes, P., Madden, S., Miskovic, J., Wallis, A., Baillie, A., . . . Touyz, S. W. (2012). Do the components of manualised family-based treatment for anorexia nervosa predict weight gain? *International Journal of Eating Disorders, 45*, 609–614.
- Geller, J., Zaitsoff, S. L., & Srikameswaran, S. (2005). Tracking readiness and motivation for change in individuals with eating disorders over the course of treatment. *Cognitive Therapy and Research, 29*, 611–625.

- Girz, L., LaFrance Robinson, A., Foroughe, M., Jasper, K., & Boachie, A. (2013). Adapting family-based therapy to a day hospital programme for adolescents with eating disorders: Preliminary outcomes and trajectories of change. *Journal of Family Therapy, 35*, 102–120.
- Haley, J. (1980). *Leaving home: The therapy of disturbed young people*. New York, NY: McGraw-Hill.
- Henderson, K., Buchholz, A., Obeid, N., Mossiere, A., Maras, D., Norris, M., . . . Spettigue, W. (2014). A family-based eating disorder day treatment program for youth: Examining the clinical and statistical significance of short-term outcomes. *Eating Disorders, 22*, 1–18.
- Hoste, R. R. (2015). Incorporating family-based therapy principles into a partial hospitalization programme for adolescents with anorexia nervosa: Challenges and considerations. *Journal of Family Therapy, 37*, 41–60.
- Katzman, D. K. (2005). Medical complications in adolescents with anorexia nervosa: A review of the literature. *International Journal of Eating Disorders, 37*, S52–S59.
- Katzman, D. K., Peebles, R., Sawyer, S. M., Lock, J., & Le Grange, D. (2013). The role of the pediatrician in family-based treatment for adolescent eating disorders: Opportunities and challenges. *Journal of Adolescent Health, 53*, 433–440.
- Kaye, W. H., Enright, A. B., & Lesser, S. (1998). Characteristics of eating disorders programs and common problems with third-party payers. *International Journal of Eating Disorders, 7*, 573–579.
- Keel, P. K., & Brown, T. A. (2010). Update on course and outcome in eating disorders. *International Journal of Eating Disorders, 43*, 195–204.
- Le Grange, D., Accurso, E., Lock, J., Agras, W. S., & Bryson, S. W. (2014). Early weight gain predicts outcome in two treatments for adolescent anorexia nervosa. *International Journal of Eating Disorders, 47*, 124–129.
- Le Grange, D., Lock, J., Agras, W. S., Bryson, S. W., Jo, B., & Kraemer, H. C. (2012). Mediators and moderators of remission in family-based treatment and adolescent focused therapy for anorexia nervosa. *Behavior Research and Therapy, 50*, 85–92.
- Le Grange, D., Lock, J., Loeb, K., & Nicholls, D. (2010). Academy for Eating Disorders position paper: The role of the family in eating disorders. *International Journal of Eating Disorders, 43*, 1–5.
- Lock, J., & Le Grange, D. (2013). *Treatment manual for anorexia nervosa: A family based approach* (2nd ed.). New York, NY: Guilford Press.
- Lock, J., Le Grange, D., Agras, W. S., Moye, A., Bryson, S., & Jo, B. (2010). Randomized control trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Archives of General Psychiatry, 67*, 1025–1032.
- Madden, S., Miskovic, J., Wallis, A., Kohn, M., Lock, J., Le Grange, D., . . . Touyz, S. (2014). A randomized controlled trial of in-patient treatment for anorexia nervosa in medically unstable adolescents. *Psychological Medicine, 14*, 1–13.
- Maguire, S., Le Grange, D., Surgenor, L., Marks, P., Lacey, H., & Touyz, S. W. (2009). Staging anorexia nervosa: Conceptualizing illness severity. *Early Intervention in Psychiatry, 2*, 3–10.

- Mond, J. M., Hay, P. J., Rodgers, B., Owen, C., & Beumont, P. J. V. (2005). Assessing quality of life in eating disorder patients. *Quality of Life Research*, *14*, 171–178.
- Murray, S. B., Griffiths, S., & Le Grange, D. (2014). The role of collegial alliance in family based treatment of adolescent anorexia nervosa: A pilot study. *International Journal of Eating Disorders*, *47*, 418–421.
- Murray, S. B., & Le Grange, D. (2014). Family therapy for eating disorders: An update. *Current Psychiatry Reports*, *16*, 447.
- Murray, S. B., Thornton, C., & Wallis, A. (2012a). A thorn in the side of evidence-based treatment for adolescent anorexia nervosa. *Australian & New Zealand Journal of Psychiatry*, *46*, 1026–1068.
- Murray, S. B., Wallis, A., & Rhodes, P. (2012b). The questioning process in Maudsley family-based treatment. Part 1: Deviation amplification. *Contemporary Family Therapy*, *34*, 582–592.
- Pompili, M., Mancinelli, I., Girardi, P., Ruberto, A., & Tatarelli, R. (2004). Suicidality in anorexia nervosa: A meta-analysis. *International Journal of Eating Disorders*, *36*, 99–103.
- Rockwell, R., Boutelle, K., Trunko, M. E., Jacobs, M. J., & Kaye, W. H. (2011). An innovative short-term, intensive, family-based treatment for adolescent anorexia nervosa: Case series. *European Eating Disorder Review*, *19*, 362–367.
- Steinhausen, H. C. (2002). The outcome of anorexia nervosa in the 20th century. *American Journal of Psychiatry*, *159*, 1284–1293.
- Strober, M., Freeman, R., & Morell, W. (1997). The long-term course of severe anorexia nervosa in adolescents: Survival analysis of recovery, relapse, and outcome predictors over 10–15 years in a prospective study. *International Journal of Eating Disorders*, *22*, 339–360.
- Treasure, J., & Russell, G. (2011). The case for early intervention in anorexia nervosa: Theoretical exploration of maintaining factors. *British Journal of Psychiatry*, *199*, 5–7.
- Wallis, A., Alford, C., Hanson, A., Titterton, J., Madden S., & Kohn, M. (2013). Innovations in Maudsley family-based treatment for anorexia nervosa at the Children's Hospital at Westmead: A family admissions programme. *Journal of Family Therapy*, *35*(S1), 68–81.
- Wiseman, C. V., Sunday, S. R., Klapper, F., Harris, W. A., & Halmi, K. A. (2001). Changing patterns of hospitalization in eating disorder patients. *International Journal of Eating Disorders*, *30*, 69–74.