The Emily Program
The eating disorder specialists

Family-Based Treatment

Family-based Treatment Overview

- Family-Based Treatment (FBT), or "The Maudsley Method," is the leading evidence-based treatment for children and adolescents with eating disorders and is considered the first-line treatment by the National Institute for Health and Clinical Excellence (NICE).

- FBT was developed at the Maudsley Hospital in London and has been studied in several research trials nationally and internationally.

- It is designed to be a brief (~10-20 sessions,~12 months) outpatient approach with 3 defined phases:

  Phase I – Weight Restoration / Symptom Cessation (led by parents)
  Phase II – Return of Developmentally Appropriate Control Back to Adolescent
  Phase III – Restore Developmental Status / Relapse Prevention

- Fundamental Assumptions – Families do not cause eating disorders (EDs) and they are the best resource for recovery; similarly, the adolescent is not the same as their illness, and did not choose to have this illness.

- Families must be prepared to make sacrifices until the crisis is resolved (work, school, activities) – this includes making every effort to attend all sessions. Each family member has a unique and important role in the recovery process.

- Treatment will focus on maintenance factors rather than the underlying (and undeterminable) causes.

- Treatment is very specific and focused – behavioral symptoms must be resolved before there is relief from cognitive/emotional symptoms.

- Food/normalized eating is considered the most potent medicine in treatment and a firm, yet empathic approach should be taken to create a zero-tolerance environment for the ED.

- Weight will be openly discussed – we work to remove the power from the number.

- We avoid walking on eggshells when addressing dangerous weight management behaviors.

- Regular monitoring by a licensed medical/healthcare provider is required throughout treatment.

- Anticipate a J-Curve Treatment Process, which means problematic eating disorder behaviors may get worse before they get better.

- Collaboration is key – we may be the experts on EDs, but you are the expert on your family!

Getting Started With FBT: Suggestions from Other Maudsley Parents

- Parents should immediately assume full responsibility for selecting, serving, and supervising all meals and snacks – it's easier to start firm and then move back once treatment progresses.
- Each time you plate your child's food, ask yourself two questions: 1) "Is this enough food to nourish my child back to health?" and 2) Am I confident that the ED did not shape my selection?" If the answer to either is "no" – make a change!
- Grocery shop without your child to avoid negotiating and to reduce anxiety in your child.
- Keep your child occupied and out of the kitchen while you are cooking, if possible, to reduce their anxiety and avoid negotiations about what and how much to serve.
- Create menus that have enough calories to reverse the process of malnutrition.
- Try to fit your child's calorie requirements into a manageable footprint – think dense! Boost the caloric value of foods by adding butter, cream, whole-fat milk, olive oil, whipped cream, etc. as appropriate. Instead of serving plain fruit, consider baking a pie, cobbler or crisp. Try french fries instead of boiled potatoes. Vegetables coated in olive oil and roasted bump up the calorie level.
- Parents should not lie or "sneak" ingredients into foods – that said, remember that you do not owe the ED any explanation for your choices. Know when to say "Because I said so."
- Stick to general answers (like "it contains the nutrients your body needs" or "it has everything you need to get well") to avoid being drawn into unproductive conversations. If arguing did not work before, it won't work now.
- If your child is engaging in self-induced vomiting, allow at least 1-2 hours to pass after a meal before they use the restroom (get them into the habit of going before!)
- It may be necessary to institute "bathroom observations," or parental supervision of all time in the restroom, if your child attempts to purge at other times (e.g. during showers).
- If your child is engaging in compensatory/compulsive exercise, it may be necessary to provide supervision at other times as well.
- Use positive distractions when you can.
- Even during the toughest moments, remember your child is worth fighting for!

Words of Wisdom from Other Maudsley Parents

- "You don't need to be a registered dietitian to do this; it isn't about getting your child to eat like they were in a hospital. It is about getting your child back to eating enough of all the foods they ate before they were ill. If your child hated peanut butter there is no reason to serve it to them. However, if they loved it, but won't eat it now because it's too fattening, that is a sure sign that for them to recover you must help them to be able to eat it again."

- "This is the hardest thing I have ever done. I had to constantly remind myself it is not my child's fault. Think of it like cancer. Food is your child's medicine. Every snack, every meal, getting better one bite at a time. It was so hard to see my daughter six times a day having to do something that she was so scared of. Each meal for her was like facing her greatest fear. And yet she did it. Today she is a happy college freshman."

- "What I mainly remember is being so sick of thinking about food! The good news is that refeeding doesn't last forever; it just seems like it does."

- "There is nothing magical about the Maudsley Approach – it's your family that makes it work."

Why Your Teen Probably Won't Want to do FBT, and Why You Should Feel Free to Do It Anyway

Lauren Muhlheim, Psy.D., FAED, CEDS-S

When I consult with parents who are considering treatment for their teen with an eating disorder, I advise that there are many things to consider. There are several different types of treatments. Family-based treatment (FBT) is an evidence-based treatment, with the best research support for the treatment of teens, and it requires parents to play an active role. I recognize that FBT is a big commitment for families, and I don't judge parents who do not feel up for the challenge.

I am an FBT enthusiast. I love doing FBT with families. At the same time, I fully admit that FBT is not for every family. It requires a degree of time commitment, active management, and capacity to tolerate distress that may not be practical for every family.

The weakest reason I get for rejecting FBT is that the teen does not want to do it. In my opinion, the child's perspective should have no bearing on whether you decide to use an effective, research-supported treatment to help them.

Imagine that your child had cancer and the most successful treatment for that cancer was a course of chemotherapy that would make the child uncomfortable and sick. If your child told you he didn't want to have that treatment, wouldn't you insist anyway? There are child decisions and adult decisions, and I believe that choosing the treatment your child receives for a life-threatening illness is an adult decision.

When I work with families, informed consent dictates that at the beginning of treatment I lay out what FBT will entail. When I describe that all meals must be supervised; that you should go to school to have lunches with your child; that sports should be curtailed; that sleepovers and other outings with friends will need to wait; that your child may require supervision between meals and in the bathroom as well; and that weight gain should be one to two pounds per week until your teen returns to their recovery weight—your teen (and their eating disorder) hears me.

Their eating disorder is understandably extremely threatened by the description of this approach and may dig in and resist. Further, no teen is excited by this level of supervision; barely any are willing to sign on to such a program! And why would they want to? Teens prize their independence and privacy. Most don't see their eating disorder as a life-threatening illness, which is a symptom of the eating disorder. This blinds the teen to the very existence of the disease. I don't expect any teen to ever willingly agree to FBT. You shouldn't expect them to either— but that should not stop you from undertaking a treatment that is in their best interest.

I hear people say that it's cruel, unusual, or controlling to insist that a starving child eat and to firmly steer them through the healing process. I reject this opinion. Administering medicine in the form of food to your starving child is an act of love and compassion. Choosing to not do FBT is choosing to not take the strongest possible stance and assert your role as a key member of your child's treatment team.

Here's a common response from the family's perspective. The mother (not a patient of mine) commented:

Of course, she didn't want to do FBT—she was a 99% independent 17-year-old with a car and a job and a college acceptance letter. Luckily, our pediatrician was emphatic that this was life or death and that FBT was the treatment with the most evidence for its effectiveness. It was a huge switch in parenting style for me, and while it was terrifying at times, it worked, and I got my feisty, fierce, full-of-life girl back.

From the teen (now a young adult):
I don't really remember a lot from the beginning of FBT because I was badly malnourished and what I do know is that there is just no way I could have chosen to eat; it had to be my parents taking charge because I couldn't. I am so grateful they did what they had to and gave me my future back.

As you decide which type of treatment to pursue for your child, I encourage you to consider what you think is in the best interest of your teen and their future health. That is your job as the parent. Fortunately, FBT is a treatment that you can pursue without their agreement. The alternatives are often less effective.

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