Addressing attachment issues in family therapy for young people with anorexia. How can we use a relational re-frame in engaging the family?

Greg Dring and Heidi Joyce

Goals

To present some ideas and to give you a brief experience of what it might be like to use relational re-framing in the engagement of the family. The ideas draw mostly on attachment theory and on "attachment-based" or "Attachment-Narrative" Dallos (2006), family therapy, and on argument in the book "Finding a Voice", Dring (2015).

Background

Why would we think about doing this? We know that Family Therapy can be a successful treatment for anorexia in young people in an acute phase, but we don't really know why. A number of different approaches reported roughly similar results. It would be useful to have more research on the *process* of therapy, but we do not have much at present.

This does not mean that it does not matter. Lock and Le Grange (2013) say that 50% of patients are not fully recovered after FBT, while according to Lock et al (2006) at least 2/3rd of patients treated with FBT needed further treatment, mostly for anxiety or depression, in a follow-up period averaging four years. So there is room for improvement.

Finding a Voice, Dring (2015) develops the following line of argument about the research on FT for AN

Early approaches, such as those described by Minuchin et al (1978) and by Russell et al (1987) were designed to tackle family relationship problems seen as giving rise to anorexia. Subsequently, Dare and Eisler (1997) stood this argument on its head. In the Maudsley model parents are told "we know that family relationships do not cause anorexia", Lock and Le Grange (2013). Relationship problems were then seen as following from the anorexia. However, the Maudsley approach does not seem to improve outcomes or reduce drop-out rates, nor has it been shown to be more successful with more difficult cases. Moreover, a great deal of evidence does point to the existence of relationship problems in the families of patients with anorexia, and there is little reason to accept that this is only because of the impact of the anorexia on the family.

Finding a Voice develops the following line of argument about therapy

A person who develops anorexia can be seen as turning away from potential sources of comfort in their family relationships, and coping with their distress by focussing attention entirely on food and weight control. That understanding is common to many different therapeutic approaches, but oddly enough, not to family therapy.

From the point of view of attachment theory the turning away implies underlying attachment difficulties.

In adolescence the relationship with the parents provides the necessary security at times of stress. If there are symptomatic behaviours the implication is that the adolescent is unable to use that support.

In addition there is now an attachment theory of the family and anorexia, Ringer and Crittenden (2007), Dallos and Densford (2008). According to this view anorexia arises in family situations where the parents unresolved difficulties about loss and trauma make parents unable to regulate and respond appropriately to their own and others emotional states, and instead become over-protective. You do not need to accept this argument to see the value of using an attachment approach in family therapy.

The structure of an attachment-based family therapy is based on the assumption that the goal is to reinstate a secure attachment relationship of adolescent to parents. This requires that:

1. The patient must be kept safe (there is no secure attachment without physical safety)
2. The therapy situation must provide a secure base
3. Attachment issues are addressed
4. The therapist will support the adolescent in saying things that it is hard for the parent to hear
5. The therapist will help the parents to listen without *premature* intervention or explanation
6. The therapy sequence would most naturally end with parental apology for past hurt, and with adolescent forgiveness and greater understanding of the parent

Seen from this point of view re-feeding by parents is an attachment intervention. That is why it succeeds when parents are supportive, and ultimately fails when they are critical. *It is not just a question of weight recovery*.

In some respects the approach overlaps with that of Robinson et al (2015 p77). They argue that Emotion-Focused Family Therapy should be integrated into the later stages of FBT. In that approach the therapist supports the parents in becoming the patients 'emotion coach'. In it the parent is taught to "acknowledge the presence of the emotion, providing the label consistent with the bodily felt sense, validating the experience and meeting the emotional need."

What we are going to do today is about the very beginning, setting up therapy as a secure base. We see this as an alternative to the Maudsley Model method of saying "we know that parents don't cause eating disorders".

What is a "relational reframe"?

A statement that links the therapeutic work to the notion that family relationships need to change in order for a patient's dis-ease to be overcome, or a problem resolved.

It implies that some families need help in their relationships and how they relate, for the patient to feel heard, validated and contained, which can then disempower the voice of the eating disorder.

A good recent published example would be that of Micucci (2008), in work with Tina, a 16-year-old girl with anorexia, who was caught in the very difficult relationship between her divorced parents. Micucci said to the family:

"Tina is losing weight and can't eat because she feels isolated and alone, unable to express her true feelings to anyone. She is wasting away not only from lack of food but also because of the absence of nurturing and sustaining relationships in her life. This deprives her of the valuable help you both can offer her to grow and become the young adult she is capable of becoming. If you are interested I will work with you, as a family, to give you the chance to begin building more sustaining relationships, so that Tina may begin to grow again."

But not every patient will give you the material for something like that. It is important to understand the context. When Micucci talked to Tina on her own he listened to her symptomatic concerns and then said she seemed very unhappy, and wondered whether there was anything else she was unhappy about. She talked about her parent's conflicts, anger about the way her father treated her mum, and concerns about her mum's unhappiness. Not every patient will give you this much information so soon.

Attachment approaches offer alternative ways to support families in dealing with the relationship issues that come up in family therapy when an adolescent in the family is in an anorexic state of mind. That is where attachment theory comes in. It has the potential to offer a better, richer, starting point that also addresses vulnerability, including the parent's potential vulnerability. It seems that it is that perceived *parental vulnerability* (at least in some cases) that underlies the Maudsley position.

Engagement

In asking the question 'How can we use a relational re-frame in engaging the family?' we mean to put the focus on the early stages of the work during which a family is engaged with the therapist in some kind of agreement to work on a therapeutic task. So this would typically be in the first, or at least in an early, session. The relational re-frame has a function in defining what that task will be. However, such reframes could also be used to re-set the therapeutic task when a change in the work seems to be necessary, or new information becomes available.

Exercise 1

Please each complete a sentence completion task "The sort of things I usually find difficult to say early on to families in which there is a teenager with anorexia are … " Take turns to complete this task. Then discuss together what each person's statements seem to convey. Is each person satisfied with the things they convey at that stage. How does it seem to affect later stages of therapy?

Attachment

If the Maudsley model emphasises the need to protect parents from concern that they might be blamed, attachment models provide a much richer approach to addressing the wide range of vulnerabilities that family members may feel about the family therapy situation itself. Although there can be a lot of parental anxiety about the conjoint therapy situation, it isn't always about being blamed by the therapist. An attachment approach gives us a frame for addressing such issues. Dallos (2006) emphasises the need for "talks about talks" in setting up the therapy. He includes in that raising the possibility that he might make people feel blamed, even though that was not his intention. He illustrates that with a case study of work with the family of a girl following in-patient treatment for anorexia, Dallos (2006 pp. 146-150). The case study does not address the problem of managing a weight loss crisis, although many of you will have to integrate that in your approach with your way of setting up the treatment.

Today we are just going to concentrate on setting up the treatment, how the therapist may explain what the work is about, and deal with "talks about talks".

Exercise 2.

In this exercise we want you to try out a way of talking to a family. This is not a role-play, it is just an exercise using a script. We want you to work in groups of four. We want one of you to play the role of the therapist, but in this instance that is just about reading out a script. You need to draw on your therapy skills to communicate seriousness and concern for the family and the patient. Other people should imagine themselves in the role of family members. So we need to ask you to identify a role for yourself in such a way that each group has at least on person in the role of a parent, and each has at least one person in the role of the patient.

We want you to imagine that you are close to the end of your first meeting with the family therapist, who has listened sympathetically to your concerns, has introduced the idea that parents will take charge of their daughters eating, and now turns to talking to you about the therapeutic task. We just want you to experience what it is like being on the receiving end of this message. Afterwards we are going to ask you to compare your experiences in your group of four, before we invite feedback in the group as a whole.

Script for exercise 2

Therapist (addressing the patient) “Your mum and dad will help you by insisting that you eat more so that you will be safe. This will be very difficult for you. Starving yourself and focusing your attention on control of your weight gives you a sense of achievement, and this is the only thing that makes you feel good about yourself and helps you to manage your feelings. To recover you have to eat and find another way to deal with the distress. Putting your feelings into words will help you. I will be here, and your parents Will be here, to help you to do that.”
Therapist: (turning to address the parents) “Your daughter is someone who has learned to keeping her anger and distress to herself. She needs to be able to talk to you about the things that upset her, and it will be important that you can listen to what she has to say, even if you do not always agree, or find it difficult to hear”.

“It can be very difficult to talk about upsetting things, whether that is about tension at meal times, or about other sorts of distress that may come up. It is important that we meet and talk about what you are all going through while you tackle the anorexia, but all sorts of difficulties can arise. Sometimes people feel too emotional, angry or sad, or sometimes they feel blamed by the therapist or by one another, so it is important to find a way that you can tell us if there are times when it is too difficult to go on right now, or that you disagree with something that has been said. How do you think all that will be for all of you, as a family?”

So this is a generic relational re-frame, and you can see that it is much less specific than the one quoted earlier, from Micucci (2009).

A generic reframe provides a structure. It will be far more effective when it is framed to fit the particular circumstances of a case. Therefore, since information is often not forthcoming in the early stages it is a structure that may need to be returned to as the therapist becomes more familiar with the issues that face each family.

Last exercise:

Looking back at what you wrote down about things it is difficult to talk to the families about, do you see ways that you might change or add to that, drawing on the material from this workshop? If you do, please discuss with your partner, what changes you would consider making. Are there discussions you would need to have with colleagues or co-therapists if you were to make such a change?

Feedback.

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