Family Based Treatment for
Adolescent Anorexia Nervosa

Purpose of the Institute

- To disseminate evidence based treatments for child and adolescent eating disorders.
- To provide training to a set standard of specific skill sets.

Institute Faculty

Daniel Le Grange, James Lock, Kristen Anderson, Colleen Alford, Linsey Atkins, Kerri Boutelle

Angela Doyle, Peter Doyle, Kara Fitzpatrick, Maria Ganci, Renee Hoste, Katharine Loeb, Andrew Wallis

The Institute provides several levels of training

- Basic Introduction to key intervention models
- Specific Training in key models
- Certification for treatment in key models
- Certification for supervision of treatment in key models
- Certification for training others in key models
- Consultation for services and program development

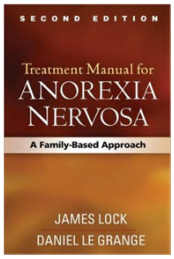
Current Institute Training

- Family-Based Treatment (FBT), also sometimes called the Maudsley Approach, for adolescent AN and BN
- Cognitive-Behavior Therapy (CBT) for adolescent BN
- Adolescent-Focused Therapy (AFT) for adolescent AN

Outline of Presentation

1. Family-Based Treatment Model
2. Background Scientific Support
3. Fundamental Assumptions
4. Setting up Treatment
5. Common Dilemmas
6. Three Phases of Treatment

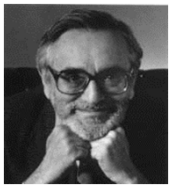
1. Family-Based Treatment Model



Historical Context of FBT

First Half - Parentectomy*: "A slang term meaning removal of a parent (or both parents) from the child." *MedicineNet.com

Second Half - Salvador Minuchin, Child Psychiatrist and founder of Structural Family Therapy



Family Therapy for EDs developed at the Maudsley Hospital

"There is little doubt that the presence of an ED has a major impact on family life. With time, food, eating, and their concomitant concerns begin to saturate the family fabric. Consequently, daily family routines as well as coping and problem solving behaviors are all affected".

Ivan Eisler, Principal Architect of the Maudsley Approach

Impact of Hospitalization

Hospitalization

Traumatic

Disempowers Parents

Overview of Family-Based Treatment

- Based on FT developed at the Maudsley Hospital in London in the 1980s
- Manualized FBT developed and systematically evaluated at UChicago (now UCSF) and Stanford University
- FBT utilizes key strategies or interventions from a variety of Schools of Family Therapy
  - Minuchin – Structural Family Therapy
  - Selvini-Palozzoli – Milan School
  - Haley – Strategic Family Therapy
  - White – Narrative Therapy

Suitability and Context

- Appropriate for children and adolescents who are medically stable
- Outpatient intervention designed to a) restore weight; and b) put adolescent development back on track
- FBT is a team approach, i.e., primary therapist, pediatrician and child & adolescent psychiatrist
- Brief hospitalization some times used to resolve medical concerns

Treatment Style

Parents in charge
- Appropriate control
- Ultimately relinquished

Therapist stance
- Active – mobilize anxiety
- Deference to parents

Adolescent Respect
- Developmental process
- Traditional treatment upside-down

Treatment Detail

Dose
- 6-12 months

Intensity
- 10-20 sessions

Format
- Conjoint
- Separated

Three Phases of FBT

Phase 1 (Sessions 1-10)	• Parents in charge of weight restoration
Phase 2 (Sessions 11-16)	• Parents hand control over eating back to the adolescent
Phase 3 (Sessions 17-20)	• Discuss adolescent developmental issues

2. Overview of the Evidence

Adolescent AN Treatment Studies

Uncontrolled Studies
- Minuchin et al (1978)
- Dare (1983)
- Martin (1984)
- Stierlin & Weber (1987; 1989)
- Mayer (1994)
- Herscovici & Bay (1996)
- Le Grange & Gelman (1998)
- Lock & Le Grange (2001)
- Wallin & Kronwall (2002)
- Le Grange et al (2005)
- Lock, Le Grange et al (2006)
- Loeb et al (2007)

Controlled Studies
- Russell et al (1987)
- Eisler et al (1997)
- Le Grange et al (1992)
- Eisler et al (2000)
- Eisler et al (2007)
- Robin et al (1994)
- Robin et al (1999)
- Lock et al (2005)
- Lock et al (2006)
- Gowers et al (2007)*
- Lock et al (2010)
- Agras et al (2014)
- Madden et al (2014)

Summary of 9 Published Adolescent AN studies

- 7 of these involved a family-focused approach (FBT or BFST)
- 3 of these involved individual therapy (supportive, adolescent focused therapy, CBT)
- 3 involved inpatient treatment
- 0 of these involved any medication
- Evidence supports effectiveness of FBT, but more comparative efficacy data are limited

Hospitalization: How Useful is It?

Sir William Gull (1816-1890)

"The patients should be fed at regular intervals, and surrounded by persons who would have moral control over them; relatives and friends being generally the worst attendants."

Charles Lasegue (1816-1883)

"In view of the undoubted psychological aspects (of the disorder), it would be equally regrettable to ignore or misinterpret the patient' s psychological surroundings."

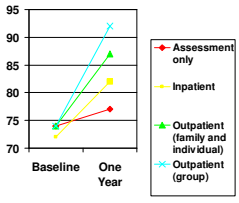
"None should be surprised to note that I always consider the morbid state of the hysterical patient side by side with the preoccupations of her relatives."

Jean Martin Charcot (1825-1893)

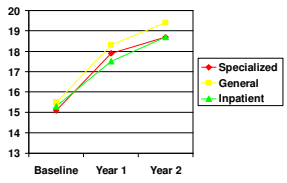
"It is necessary to separate both children and adults from their father and mother, whose influence, as experience teaches, is particularly pernicious"

Hospitalization for Adolescent AN

Crisp et al 1991

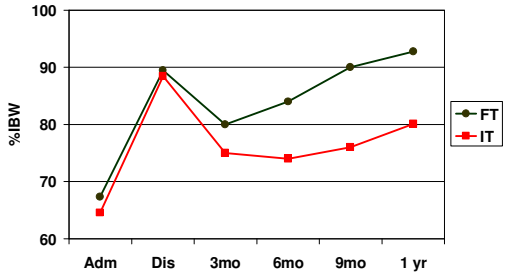


Gowers et al 2007



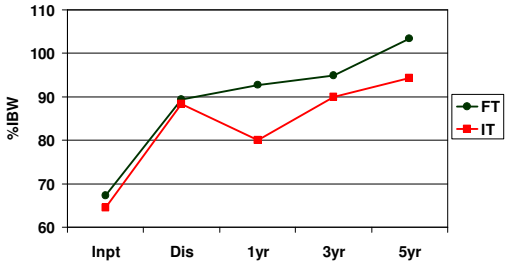
How Effective is Individual Therapy?

Weight Chart for Patients in Subgroup 1 (End of Tx)



Russell, Szmukler, Dare and Eisler (1987)

Weight Chart for Patients in Subgroup 1 (Five Year Follow-up)



Eisler I, Dare C, Russell G, Szmukler G, Le Grange D, & Dodge E. (1997)

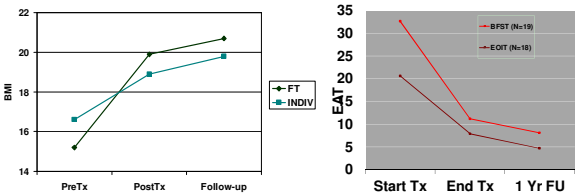
Hilda Bruck

"Excessive concern with the body and its size, and the rigid control over eating, are late symptoms in the development of youngsters who have been engaged in a desperate fight against feeling enslaved and exploited, not competent to lead a life of their own."

Arthur Crisp (1930-2006)

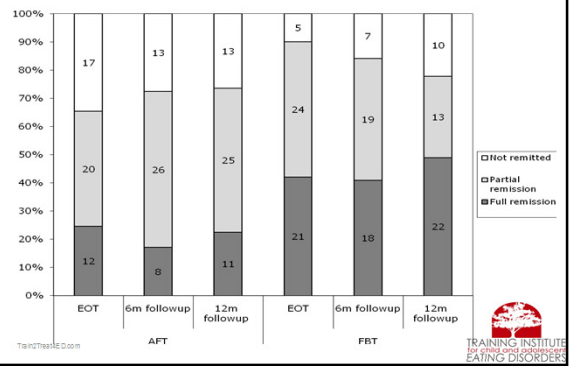
"The avoidant position in anorexia nervosa is therefore a profoundly psychosomatic one, rooted in the seemingly miraculous and certainly unique capacity to reverse pubertal process and hence all of its social and psychological impacts."

Individual Therapy for Adolescent AN



Developmentally Focused Therapy (Robin et al 1999)

Remission Rates for AFT and FBT



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End of Treatment Outcomes

- No difference in remission rates; FBT superior to AFT in partial remission (p=.055; ES=5)
- Change in percentile BMI significantly greater in FBT than AFT (p =.049; ES=5)
- Change in Global EDE total score significantly greater in FBT than AFT (p=.027; ES=4)
- Remission rates greater in FBT (49%) than AFT (23%) at 6 month (p=.03; ES=5)and 12 month follow-up (p= .02; ES=4)

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Other Findings

- Dropout, though low in both treatments, no differences between the two groups.
- By 3 months 38% (N = 23) of FBT participants had reached 95% IBW vs 20% (N = 12) in AFT F(1,105)=5.5 p=.021)
- Hospitalization: Significantly more participants were hospitalized in AFT (n=32; 37%) compared to FBT (n=9; 15%), p.02) during treatment.

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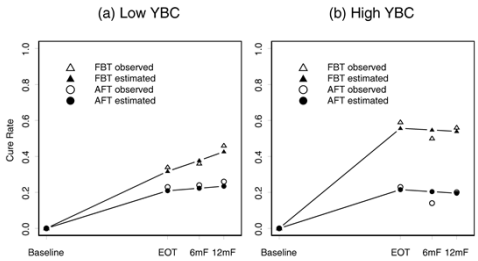
YBC-ED



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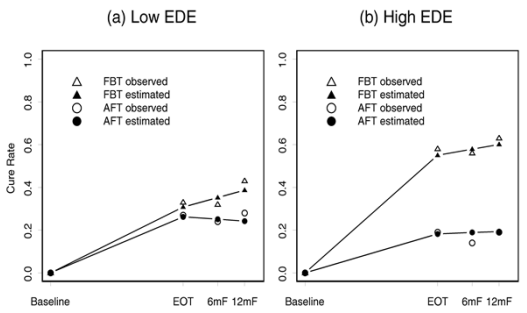
EDE Score



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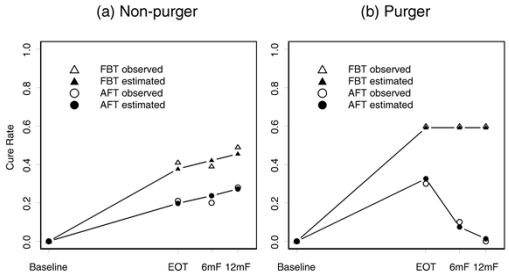
Binge-Purge sub-type



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Therapeutic Alliance

- Therapeutic alliances were strong for both adolescents and parents throughout treatment (Pereira et al, 2006; Forsberg et al 2013)
- Early patient therapeutic alliance (bond) predicted early weight gain (Pereira et al, 2006)
- Early parental therapeutic alliance predicted staying in treatment (Pereira et al, 2006)
- Early weight gain predicted end of treatment EDE scores and therapeutic alliance (Pereira et al, 2006)
- Therapeutic alliance better in AFT than FBT, but no effect on outcome (Forsberg et al 2013)

FBT vs Systemic Family Therapy

- Seven site study comparing FBT to SFT
- 164 adolescents randomized
- No differences in outcomes between groups on weight change.
- FBT leads to quicker weight restoration (F(1,146) = 8.8, p=.003),
- Fewer hospital days (8.3 days for FBT and 21.0 days for SFT--Mann Whitney U=51, p=.02, NNT=2), and lower treatment costs ($8,963 for FBT vs $18,005 for SFT. The average costs per individual recovered were $21,847 for FBT and $46,465 for SFT.
- For patients with elevated CYBOC scores, SFT was more effective.

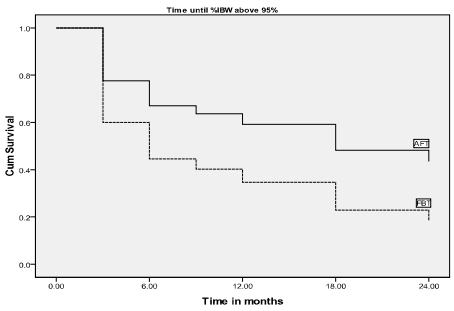
Impact of FBT on Treatment Process: Rates of Response, Dose and Hospitalization

Early Weight Gain and Outcome
FBT (N=65); FBT and AFT (N=121)

- Weight gain >4 lbs. by wk 4 correctly characterized:
  - 79% of responders [AUC = .814 (p<.001)]
  - 71% of non-responders [AUC = .811 (p<.001)]

Doyle, Le Grange, Celio-Doyle, Loeb & Crosby, *IJED*, 2009; Le Grange, Accurso, Lock, Agras & Bryson, *IJED*, 2013.

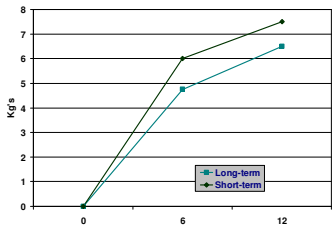
Time until >95%EBW



Le Grange, Accurso, Lock, Agras & Bryson, IJED, 2013.

Stanford Dosage Study

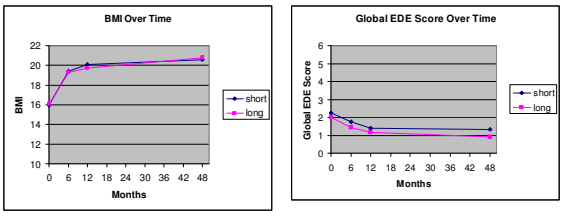
- 86 adolescents with AN
- Long-term FBT
- Short-term FBT



Lock et al. (2005)

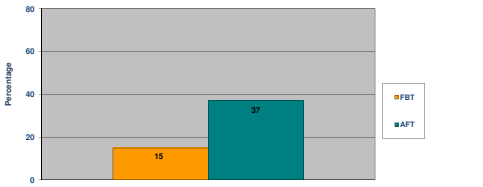
Stanford Dosage Study

48 Month Follow-Up



Lock et al. (2006)

Reducing Need for Hospitalization



p=.020

Lock, Le Grange, Agras, Moye, Bryson & Jo, *Arch Gen Psychiatry*, 2010.

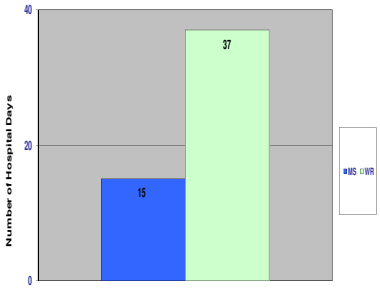
Reducing Need for Hospitalization

Westmead RCT (N=82)

MS n=41

WR n=41

One year FU



Madden, Miskovic-Wheatley, Wallis, Kohn, Lock, Le Grange, Jo, Clarke, Rhodes, Hay & Touyz, *Psychol Med,2014*.

How does this compare to inpatient refeeding?

- Strober et. al. (1997)
  - 30% relapse within 15mo (highest risk up to 9 months)
- Steinhausen et al. (1993)
  - 27% re-adm => 56% 1+ further adm (re-admission mostly within 3 years)
- Lay et al. (2002)
  - 23% re-adm => 78% after further admission

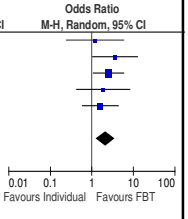
Dissemination Effects on Reducing Need for Hospitalization

- FBT was implemented in 2004 at Westmead Children's Hospital, Sydney, reporting a 50% decrease in readmissions over the implementation period (Wallis et al., 2007).
- FBT was implemented in 2009 at RCH in Melbourne, reporting 56% decrease in admissions, 75% decrease in readmissions, and 51% decrease in overall hospital days (Hughes, Le Grange, Court et al., J Ped Child Care, 2013).
- Role of peds in FBT is unique, challenges to peds trained in earlier ED treatment approaches, but effective support of the approach is critical to its success (Katzman, Peebles, Sawyer, Lock & Le Grange, J Adolesc Health, 2013).

Meta-analysis of Remission at 6-12 Month Post Treatment Results (Couturier et al, 2012)

Study or Subgroup	FBT Events	FBT Total	Individual Events	Individual Total	Weight	Odds Ratio M-H, Random, 95% CI
Ball and Mitchell 2004	7	12	7	13	10.1%	1.20 [0.25, 5.84]
le Grange et al. 2007	12	41	4	39	16.6%	3.62 [1.05, 12.44]
Lock et al. 2010	22	61	11	60	36.1%	2.51 [1.09, 5.80]
Robin et al. 1999	15	19	12	18	11.6%	1.88 [0.43, 8.20]
Schmidt et al. 2007	12	41	9	44	25.6%	1.61 [0.60, 4.35]
Total (95% CI)		**174**		**174**	**100.0%**	**2.14 [1.29, 3.53]**
Total events	68		43			

Heterogeneity: Tau² = 0.00; Chi² = 1.70, df = 4 (P = 0.79); I² = 0%
Test for overall effect: Z = 2.96 (P = 0.003)



3. Fundamental Assumptions Underlying Family-Based Treatment

Fundamental Assumptions

1. Agnostic view of cause of illness
   - Neither parents nor adolescent are to blame
2. Non authoritarian therapeutic stance
   - Joining with family
3. Parents are responsible for weight restoration
   - Empowerment
4. Externalization
   - Separation of child and illness
5. Initial focus on symptoms
   - Pragmatic

1. Agnostic View

No blame (but does not mean no responsibility)

No guilt (but does not mean no anxiety)

Therapist does not pathologize (either directly or indirectly)

Do not look for cause of illness (etiology is not the focus of treatment)

Strategies to Maintaining Agnosticism

- Do not pathologize
- Practice forgetting what you think you know
- Do not theorize - work with what's in front of you
- Work with and encourage strengths, not weaknesses
- Use supervision to identify problems in maintaining perspective
- Intervene with serious pathology (abuse, neglect) supportively and immediately

Practice Forgetting What You Think You Know

- I do not consider it an insult, but rather a compliment to be called an agnostic. I do not pretend to know where many ignorant men are sure -- that is all that agnosticism means." - Clarence Darrow
- "Extraordinary claims require extraordinary evidence." - Carl Sagan
- "In all affairs it's a healthy thing now and then to hang a question mark on the things you have long taken for granted." - Bertrand Russell
- "If you see a man approaching you with the obvious intent of doing you good, you should run for your life." - Henry David Thoreau

2. Therapeutic Stance

- Therapist serves as expert consultant
- Therapist is active in treatment
- Therapist does not control parents or patient
- Most decisions are left to parents
- This consultative stance supports therapeutic autonomy for parents

Being a good consultant

- Know the medical and psychological literature on ED
- Know how adolescents with EDs "think"
- Set specific goals about changing eating and weight loss behaviors with family
- Involve the entire family
- Help family anticipate process (j curve)
- Don't overwhelm with information
- Remember families will want you to tell them what to do and when you do they will fail and blame you
- Join the family in solving problems

3. Parental Empowerment

- The family is a resource for helping the patient
- Most families can help their child
- The family has skills to bring to the treatment
- The therapist leverages parental skills and relationships to bring about change

Strategies for Empowerment

- Listening and asking, not telling
- Suggestions, not orders
- Advice, not prescriptions
- Information, not instructions
- Support and positive feedback, not criticism
- Use examples

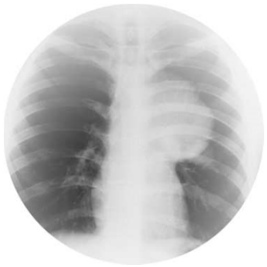
4. Separation of illness from adolescent ("Externalization")

- The adolescent is not to blame
- No pathologizing of patient (not regressed, immature, or seeking attention, but ill)
- Respect adolescent without negotiating with ED
- Supports increased autonomy with recovery from ED

Strategies for Externalization

- Disease model (cancer)
- Possession model (alien)
- Intellectual model (Venn diagram, eclipse)
- Psychological model (behavioral regression)

Disease Model



Possession Model

Intellectual Model

Psychological Model (Behavioral Regression)

5. Initial Symptom Focus

- Emphasis is first on behavioral change
- History-taking focuses on symptom development
- Delay of other issues until patient is less behaviorally and psychologically involved with ED
- No direct focus on cognitive symptoms of the ED

Strategies for Remaining Focused

- Use weight chart
- Avoid “other issues” e.g. etiology, causation
- Initial strategy is to limit medical impact of ED
- Keep tasks of session in mind – i.e., follow the manual

Focus on eating and gaining weight

Effects of FBT Tenets?

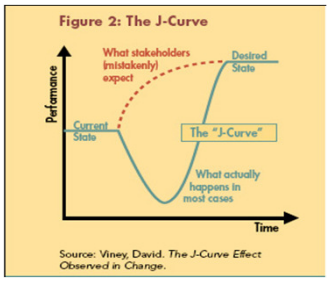
- Highly focused, staged treatment
- Emphasis on behavioral recovery rather than insight and understanding or cognitive change
- This approach might indirectly improve family functioning and reduce eating related cognitive distortions for the adolescent

Treatment Process

Treatment Process Illustration

Treatment Process Illustration

Treatment Process Illustration



3. Setting up Treatment

Core Eating Disorder Evaluation

- Interview with the adolescent
- - EDE + PEDE (Structured Eating Disorder Assessment)
- - K-SADS or MiniKid
- - Other paper-and-pencil tests
- Interview with the parents
- Medical evaluation and plan for outpatient treatment

Setting up Treatment

Therapist Call to family

- Key words are 'crisis' & 'same page'
  - Establish that there is a crisis in the family
  - Explain the context of treatment, i.e., the treatment team and the family and the importance of being on the same page
- Begin process of enhancing parents' authority to manage this crisis
- Reinforce the necessity of all family members attending the sessions

The Team

FBT is a team approach

Primary therapist (FBT)
(Responsible for FBT and coordinating care)

Pediatrician/Adolescent Medicine
(Responsible for the medical safety of patient)

Child/Adolescent Psychiatrist
(Manages any psychiatric disorder)

Expertise required to Practice FBT

Mental Health Professional (Therapist)

- Child and Adolescent Psychiatrist
- Psychologist
- Social Worker
- Nurse Therapist

Experience working with adolescents and families

Eating disorder expertise

Changing Roles of Team Members

- Lead therapist (psychologist/psychiatrist/social work therapist)
- Psychiatrist
- Adolescent Medicine/Pediatrics
- Nutritionist

4. Common Dilemmas

Fitting Patients to Treatment

- Divorced parents
- FBT assumes that the family eats together
- Family = those persons living in the same household
  - May include non-biological parents
  - May exclude those not involved in day-to-day care
- Family psychopathology
- Little data to support excluding parents
  - Parental discord
  - Parent with serious psychiatric/medical dx
  - Parent with ED

Scared Parents

Scared Therapist

Fitting Patients to Treatment

Single-Parent Households

- Therapist is important resource
- Find additional adult ally (e.g., grandparent)
- Treatment might take longer
- Child parentified

Single-Child Families

- Patient could feel unsupported
- Therapist take on even more supportive role
- Therapist has to balance support between parents and child
- Role of friends

Fitting Patients to Treatment

Co-morbidity

- Mood disorder
  - Primary or secondary?
  - Medication?

Anxiety disorder, e.g., OCD

- Primary or secondary?
- Medication?
- More treatment?

- Only acute suicidality trumps self-starvation
- Keep an eye on the ball!

Fitting Patients to Treatment

- Community Resources

- If you work outside a medical center
  - Therapy pairs
  - Establish relationship with another clinician
  - Weekly consultation
  - Weekly teem meeting or teleconferencing

- FBT in different settings
  - Inpatient units
  - Partial programs
  - Residential programs

Phase 1: Weight Restoration

Overview of Phase 1

- Focus is on helping parents take control of weight restoration processes
- Lasts between 8-10 sessions, usually weekly
- Designed to help parents do at home what nurses would do on an inpatient unit
- Principle aim is to help parents disrupt severe dieting, exercise, and related dysfunctional behaviors that are leading to/maintaining low weight

Session One

Goals:

- Engage the family
- Obtain a history of how AN affects family
- Assess family functioning (coalitions, conflicts)
- Reduce parental blame

Interventions include:

- Greeting family in sincere but grave manner
- Using circular questioning to obtain history
- Separating illness from patient
- Orchestrating intense scene concerning AN
- Charging parents with the task of weight restoration
- Summary of session, instructions for family meal

Goal: Engaging the Family

- Families are often too anxious or not anxious enough - need to get them in the therapeutic window to accept the possibility of change
- Need to create a type of therapeutic bind - warm but worried and firm

Goal: Take a Focused History with the Family

- Use the history taking process to engage all family members in developing a shared narrative of how AN developed and is changing the family
- The therapist must keep the history taking highly focused

Goal: Assess Family Functioning

- Purpose is NOT to identify family problems in a general sense
- Identify specific problems that the family might have that interfere with their ability to work together to achieve weight restoration
- Common problems include: parents not aligned, one parent over-identified with or anxious about the patient, disengaged parent, conflicts between parents, conflicts between siblings
- These exist in all families; particularly under conditions of stress and do not cause illness, but can help maintain patterns of illness behaviors

Goal: Reduce Parental Blame

- Purpose is to help increase parental confidence in their ability to help their child - guilt reduces self-efficacy
- Guilt should be confronted directly, as many parents feel guilty if their child becomes ill for any reason, but particularly with psychological illnesses, and even more particularly, eating disorders
- Parents may also feel guilt throughout renourishment process if they feel they are not "helping enough"
- This guilt interferes with problem-solving

Intervention 1: Greeting the Family

- Make eye contact with each family member
- Ask each family member a bit about themselves (interests, grade, work)
- Briefly orient the family to the phases of treatment, particularly the first phase
- Manner is serious while welcoming

Intervention 2: Circular Questioning for History of ED

- Open the session by asking the family as a whole about the onset and course of the ED
- Ask another family member for confirmation, elaboration, or editing of previous comment
- Make sure all family members contribute

Intervention 3: Separating the Illness from the Patient

- Purpose is to free parents to take definitive action to disrupt weight loss and promote weight gain
- There is sometimes protest from the patient, but use the history to provide evidence that there was a time when things were different
  - "driving under the influence of anorexia"

Intervention 4: Orchestrate an Intense Scene

- Purpose is to summarize the information gathered about how AN developed and combine it with the facts about the seriousness of AN to raise the anxiety of family members about the need to take action
- Include information about mortality, morbidity, long term outcome, value of early intervention, effectiveness of parents

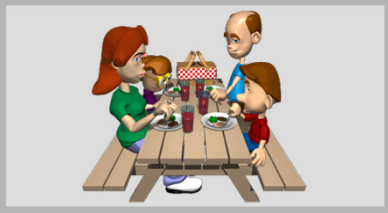
Intervention 5: Charging Parents with Task of Weight Restoration

- Purpose is to bring the need for action to a head by telling the parents that they are the best resource for helping their child
- This should be delivered warmly, with assurances of assistance from the therapist, but also firmly and with confidence that, with effort, they will succeed

Intervention 6: Summary and Instructions for the Family Meal

- Purpose is to highlight the main learning from the session and to anticipate the next session
- Brief in duration and sharp in focus
- Instructions for family meal
- Ask parents to bring a meal that the two of them decide will help their child gain weight
  - "Bring a meal that will help renourish your starving child"

Session Two: The Family Meal (Not a picnic!)



Session Two: The Meal

Major Goals of Session:

- Assess family structure as it may affect ability of parents to restore the adolescent's weight
- Provide opportunity for parents to succeed in convincing adolescent to eat more than intended
- Assess family process during eating

Session Two: The Meal

Interventions in Session:

- Weighing the patient
- Taking a history, observing family patterns around eating, learn about food preparation, food serving, and discussions around meal times
- One more bite
- Aligning patient with siblings for support

Remainder of Phase 1

Remainder of Phase 1: Sessions 3-10

Goals:

- Keep the family focused on the AN
- Help the parents take charge of child's eating
- Mobilize sibling support for patient

Remainder of Phase I: (Sessions 3-10)

Interventions Include:

- Weighing the pt at start of each session
- Directing, redirecting, and focusing the discussion on food and eating
- Supporting parental dyad, modifying criticism toward pt, externalizing illness
- Helping family to evaluate efforts of siblings to support their sister

Issues specific to Phase I

- Balance between meeting adolescent on her own and meeting family as a whole
- Weighing the patient and how to manage the number with the adolescent
- Sharing the weight chart with family with weight setting the tone of the meetings
- Working out with the parents how they can help their adolescent restore weight
- Helping the family to get their 'ducks in a row'(facilitating parental learning)
- It's OK to be a little pedantic!

By the end of Phase 1…

Phase II

Phase II (Sessions 11-16): Help Adolescent Eat Independently

Guidelines for transition to Phase II:

- Weight is usually at a minimum of ~90% IBW
- Patient eats without significant struggle under parental supervision
- Parents report they feel empowered to manage illness

Phase II

Goals:

- Maintain parental management until pt can gain weight independently
- Transfer food/weight control to adolescent
- Encourage the adolescent to engage in normal adol activities that involve peers, eating and exercise

Phase II

Interventions Include:

- Weigh patient at every session
- Assist parents in managing the ED and in navigating return of control of eating
- Continue to assist siblings in supporting their sister
- Continue to highlight differences between adolescent's own needs and those of AN
- Closing sessions with positive support

Phase III: Tracking Back to Normal Adolescent Development

Phase III (Sessions 17-20): Adolescent Issues

Assessing Readiness:

- Symptoms have dissipated (weight > 90% IBW), but some shape and weight concerns may remain

Goals:

- Revise parent-child relationship in accordance with remission of AN
- Review and problem-solve re. adolescent development
- Terminate treatment

Phase III

Interventions include:

- Review normal adolescent development; establish that patient is back on normal trajectory in all domains
- Model problem-solving behavior
- Check parents relationship as a couple
- Discuss fear of relapse; plan
- Terminate

Review Adolescent Development

- Puberty and body adjustment (ages 11-13)
- Social identity and roles (ages 14-16)
- Intimacy and leaving home (ages 17-18)

Getting Started

- Interview parents about each stage
  - Changes focus from the adolescent
  - Creates empathic "memory" in parents about dilemmas of adolescence
  - Normalizes adolescent experience
- Psychoeducation

Identifying Key Adolescent Issues

- Create dialogue between parents and adolescent about adolescent issues they're facing (depends on age of patient)
  - Sex
  - Drugs
  - Friends
  - Rules

Brief Work on Key Issue

- Assign/ask parents and adolescent to pick a key issue and work out how they want to solve it
  - Provides analogue for parents and child to solve adolescent dilemmas
  - Not meant to be general adolescent therapy
- Identify issues that need further work beyond FBT

Termination

Termination starts with Session 1

- Empowering family from outset makes termination less of an issue
- Decreasing frequency of sessions over the course of treatment makes termination less of an issue
- Identify current status (revisit Venn diagram)
- Referral for additional treatment for other problems, if necessary