Adolescent Eating Disorders: Working With Families

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Outline of this Presentation

① The case of Leah
② FBT History and background
③ Empirical Evidence
④ Family Video
⑤ Closing Remarks and Discussion
The Case of Leah

An Adolescent with Anorexia Nervosa
Leah – 13 yr old Caucasian female

Presenting Problem

- At least 9 mo hx of weight loss
- Wt ~110 lbs (age 12) when restricted eating started
- Lost 20 lbs primarily through dieting and increased exercise
- Pt fainted at PCP’s office raising everyone’s concern
- Presented to us at 95 lbs (ht = 64 inches)

- BMI = 16.3 (12\textsuperscript{th} percentile for age)
- More meaningfully, this pt has lost ~ 15\%EBW
- No binge eating and/or purging
- Primary amenorrhea
Leah – 13 yr old Caucasian female

Treatment History

- Limited prior treatment
- Wkly indiv sessions w/ psychologist for 2 mo prior to assessment
- Concurrent sessions w/ nutritionist (meal plan)
- Encouraged parental supervision at home and counselor at school
- Some wt gain, progress frustratingly slow
- Parents concerned about new school year and lack of oversight

- Process also frustrating for pt
- Discomfort with ‘eating too much’, wishing to remain ~ 90 lbs
- Mealtimes a struggle, throws snacks away and leaves meals unfinished when not noticed
- Intrusive thoughts (shape and wt), interferes w/ school work + athletic endeavors
Leah – 13 yr old Caucasian female

Psychiatric History

- Gaining wt = distress
- Episodes of anger and frustration, cries in room or throws things around
- Feeling upset most days, lasting ~ 1 hr, able to distract herself
- Thoughts about hurting herself, no intent or plan
- No hx of self-injurious behavior
- Does not meet criteria for MD

- Endorses considerable anxiety
- Describes herself as a worrier, e.g., family finances, ‘something bad happening’ to parents
- Lies awake ~1 hr at night before falling asleep
- Cannot ‘sit still’, irritable, short with others, unable to concentrate
- Meets criteria for GAD
Leah – 13 yr old Caucasian female

Family History

- Intact family, profess. parents, 2 younger sibs, brother 12 and sister 9
- Siblings have a ‘normal relationship’ with periodic disagreements
- Parents report that siblings are concerned about their sister not eating
- Family is well-informed and supportive and everyone is committed to attending FBT
- Conflict between mother and pt at mealtimes, yet strong relationship
- Pt has fears and anxiety that something might happen to her mother
- Does not meet criteria for separation anxiety disorder
- Pts great grandfather suffered from MD, no other family psychiatric hx of note
Leah – 13 yr old Caucasian female

Social History

- Conscientious student (Straight A’s)
- ‘Perfectionistic’ habits, almost maladative, according to parents
- Extracurricular activities, e.g., cross-country team
- Parents leveraged continued participation in running against wt gain
- Coach supportive, ‘if you don’t eat, you don’t run’
- School environment of concern
- Parents report that many of Leah’s peers are ‘quite disordered’ in their eating
- Leah picked for school modeling project because she was the ‘skinniest’
- Peer pressure to ‘get down to 90’
- Social life is restricted with few good friends
Assessment

• EDE + PEDE
• KSADS/MiniKid
• Paper-and-pencil tests
• Medical Evaluation
• Psychiatric Evaluation (if necessary/indicated)
Diagnosis – DSM-IV

- **AXIS I:** Anorexia nervosa, restricting subtype 307.1
  Generalized Anxiety Disorder, 300.02
- **AXIS II:** None
- **AXIS III:** Amenorrhea
- **AXIS IV:** Social group at school
- **AXIS V (GAF):** Current: 60; Highest in past year: 65
Treatment Priorities

- AN - medical and psychosocial complications
- GAD - pre-existing, exacerbated by AN or a consequence of AN?
Treatment Plan

 AN - medical and psychosocial complications
   Medical follow-up
   Course of outpatient FBT (~20 sessions)

 GAD - pre-existing, exacerbated by AN or a consequence of AN?
   Postpone pharmacotherapy or other direct intervention
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
Treatment Outcome

- Completed course of outpatient FBT (18 sessions)
- Medically stable
- Weight is >115 lbs, BMI=19.7, and 101% EBW
- Menses started 8/12 ago, has been regular since
- No significant anxiety
- Transfers to high school this summer with great excitement
- Peer relationships more developed
- Some appropriate adolescent experimentation outside the home
Weight Chart for Leah

*Not to scale; +Menses started
② Family-Based Treatment

*History and Background*
“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.”

William Gull
(1816-1890)
“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.”
“It is necessary to separate both children and adults from their father and mother, whose influence, as experience teaches, is particularly pernicious.”

Jean Martin Charcot
(1825-1893)
The 20th Century

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
The Maudsley Approach

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
Family-Based Treatment Model

The Maudsley Approach
The Maudsley Approach

Hospitalization

Traumatic

Disempowers Parents
Family-Based Treatment

- Developed at the Maudsley Hospital in London in the 1980s
- Continues to be refined at Chicago, London, Melbourne, Mt Sinai, Stanford, Sydney and other centers
- Takes 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
Family-Based Treatment

- Theoretically agnostic – no assumptions about the origin of the disorder, focus on what can be done
- Parents are a resource with no blame directed to either the parents or the ill adolescent
- Siblings play supportive role and protected from the job assigned to the parents
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 to resolve medical concerns
What does this treatment look like?

Adolescent Anorexia Nervosa
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)
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**Phase 3**
(Sessions 17-20)
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③ Evidence-Based Treatment

Adolescent Anorexia Nervosa
First Uncontrolled Study: Structural Family Therapy

Characteristics
- 53 patients
- Ages 9-21 years
- 16 therapists

Problems
- No outcome measures
- No control group
First Maudsley RCT (N=80) Subgr. 1 + 5 Yr FU

- FBT n=10
- Supportive therapy n=9
- 12 months Tx post hosp
- 5-year FU

Russell, Szmukler, Dare, Eisler, *Arch Gen Psych*, 1987; Eisler, Dare, Russell, Szmukler, Le Grange, Dodge, *Arch Gen Psych*, 1997.
Conclusions

- Family therapy was found to be more effective than individual therapy in patients whose illness was not chronic and had begun before the age of 19 years.

- Much of the improvements found at 5-year follow-up can be attributed to the natural outcome of the illness. Nevertheless, it was still possible to detect long-term benefits of family therapy completed 5 years previously.
Second Maudsley RCT (N=58)

- Pilot n=18
- Larger study n=40
- Conjoint FT (CFT)
- Separated FT (SFT)
- 4-Year FU

Conclusions

➢ On global measure of outcome, the two forms of family therapy were associated with equivalent end of treatment results.

➢ For those patients with high levels of maternal criticism toward the patient, SFT was shown to be superior to the CFT.
Detroit RCT  
(N=37)

- BFST n=19
- EOIT n=18
- 12-18 months of Tx
- 1 year follow-up

Conclusions

- BFST and EOIT proved to be effective treatments for adolescents with AN, but BFST produced a faster return to health.
Stanford Dosage Study (N=86)

- Long-term FBT
- Short-term FBT
- 12mo vs 6mo Tx
- 48mo FU

Conclusions

- A short course of family therapy is as effective as a longer course.
- These good outcomes were maintained at 4-year follow-up.
Liverpool RCT
(N=167)

- CAHMS n=55
- Specialized Outpt n=55
- Inpt treatment n=57
- One and two year FU

Conclusions

- First-line in-patient psychiatric treatment does not provide advantages over out-patient management.

- Out-patient treatment failures do very poorly on transfer to in-patient facilities.
Chicago/Stanford (N=121)

- FBT n=61
- AFT n=60
- Six and 12mo FU

Conclusions

- FBT is superior to AFT in promoting full remission at follow-up.
- FBT is superior to AFT in promoting partial remission at EOT, but diminishes over time.
- Participants in FBT consistently reach weight restoration target quicker than in AFT.
- Maintenance of remission in FBT is superior to AFT.
FBT in Clinical Practice

Adolescent Anorexia Nervosa
Chicago Case Series (N=45)

*BMI*

$t(44)-8.153, \ p<.001$

Columbia Open Trial (N=20)

Tx Response
- 75% completed full course of treatment
- 67% menstruating by end of treatment
- %IBW changed from 81.9 to 94.1 (p=.000)
- Sign changes in EDE Res, EC, binge/purge, and BDI

Time to Recovery
(Mean BMI)

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BMI

Time (wks)
Rate of Weight Gain in FBT (N=65)

Weight gain >1.36 kgs at week 4 correctly characterized:

- 79% of responders [AUC = .814 (p<.001)]
- 71% of non-responders [AUC = .811 (p<.001)]

How Much Weight in FBT before ROM (N=84)

Menses typically return at 95% EBW

- All participants presented with secondary amenorrhea
- Menses resumed on average at session 13/20 of FBT


Faust, Goldschmidt, Anderson et al., in prep.
Summary Findings

- Preliminary support for the feasibility of an outpatient approach with active parental involvement in the treatment of C&A AN.
- FBT can be successfully disseminated, replicating high retention rates and significant improvement in the psychopathology of adolescent AN seen at the original sites.
- Adolescents with AN, receiving FBT, who show early weight gain are likely to remit at end of treatment.
Implications for AN

- FBT should be the first line intervention for adolescents with AN who are medically fit for outpatient treatment

- Most patients respond favorably after relatively few treatment sessions if illness is recognized early on

- AFT could be a credible alternative for some patients
④ Family Video
Closing Remarks
Resources, Current Studies and Conclusions
Resources

- Family-Based Treatment can be successfully disseminated
  - Clinician Manual for AN  (Lock & Le Grange, 2012)
  - Clinician Manual for BN  (Le Grange & Lock, 2007)
  - Parent Handbook  (Lock & Le Grange, 2007)
  - Parent Case Book  (Alexander & Le Grange, 2009)
  - Clinician Handbook  (Le Grange & Lock, 2011)

- www.train2treat4ed.com
Current Studies for AN & BN

- Several studies are currently underway
  - FBT-AN vs Inpatient Tx (Westmead Hospital)
  - FBT-AN vs FT (Six sites in US and Canada)
  - FBT-PO vs NEC (Mt Sinai, NY & Chicago)
  - FBT-AN vs PFT (Chicago & Melbourne)
  - FBT-SAN vs SPT (Mt Sinai, NY)
  - FBT-AN vs MFGT (Maudsley Hospital)
  - FBT for Young Adults with AN (Chicago)
  - CBT-A vs FBT-BN (Chicago & Stanford)
  - Adaptive FBT (Chicago & Stanford)
Conclusions

- FBT for children and adolescent AN patients with short duration illness is promising
- Most patients respond favorably after relatively few outpatient treatment sessions
- FBT as effective in brief form as in longer form; in conjoint form as in separated form
- The beneficial effects of FBT are sustained at 4-5 year follow-up