

Family Based Treatment for Anorexia nervosa



HSE National Clinical Programme for Eating
Disorders

Overview

- To provide CAMHS with background information and context for the roll out of Family Based Treatment (FBT) as part of the national clinical programme in eating disorders
- To provide an overview of FBT content and structure
- To facilitate conversations to take place in CAMHS MDT level as to how FBT integrates into care planning for adolescent patients with anorexia nervosa

The clinical focus for FBT is anorexia nervosa

DSM V: 2014

- **Anorexia Nervosa**
- Bulimia nervosa
- Binge Eating Disorder
- Avoidant/ Restrictive Food Intake Disorder (ARFID)
- Elimination Disorders
- Pica and Rumination disorder
- Other specified eating and feeding disorder (OSFED)

ICD: 10 – 1996

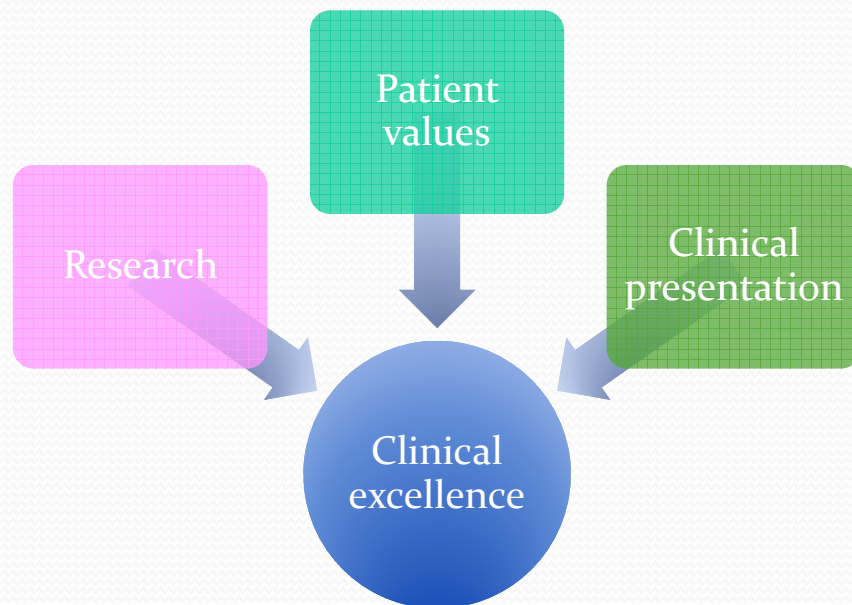
- **F50.0 Anorexia nervosa**
- **F50.1 Atypical anorexia nervosa**
- F50.2 Bulimia nervosa
- F50.3 Atypical bulimia nervosa
- F50.4 Overeating associated with other psychological disturbances
- F50.5 Vomiting associated with other psychological disturbances
- F50.8 Other eating disorders
- F50.9 Eating disorder, unspecified

Overview of the evidence and theory behind FBT



Key sources of information

Clinical decision making

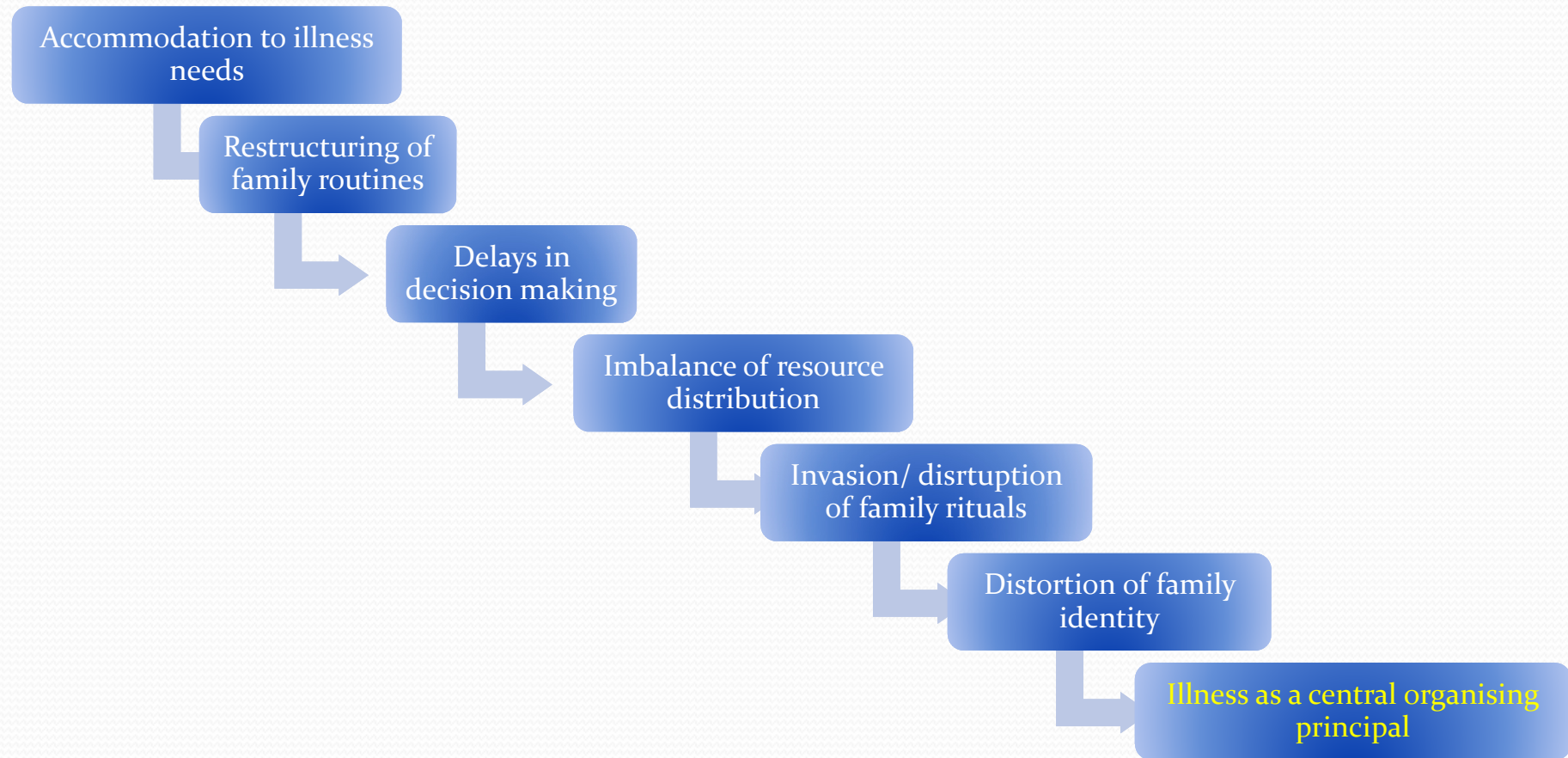


Kings Fund, (2012)

Sources of evidence

- Body of research
- Best practice Guidelines
 - AACAP Practice Parameters 2015
 - RANZCP Clinical Practice Guidelines 2014
 - NICE Guidelines (2004- bring updated currently- due 2017?)

How families reorganise around illness



(adapted from Steinglass, 1987- The alcoholic family)

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Systemic family therapy

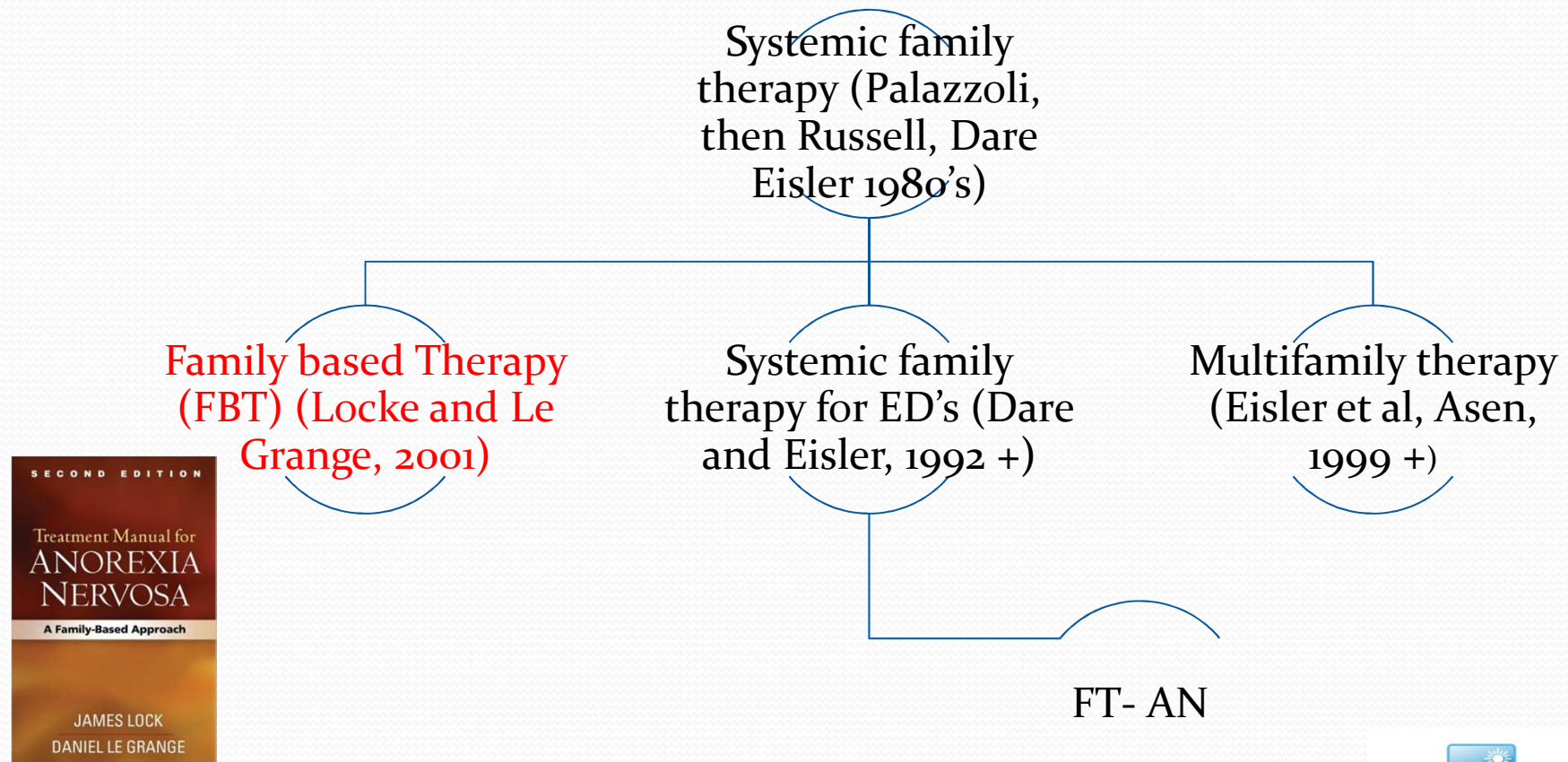
1980's: Maudsley group:

- *What if this also applies to anorexia?*
- *What if what we are seeing is a reaction to eating disorder in the family rather than a cause?*



- ED is central and in control
- Life cycle needs not being met (Erikson)
- Family feels helplessness
- 'Here and now' thinking
- Restricted family interaction

From this a key school of family therapy for eating disorders developed at the Maudsley Hospital



The future: third generation- special populations?
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So, what is Family Based Treatment (FBT)?

- Based on FT developed at the Maudsley Hospital in London in the 1980s
- Manualized and developed as FBT and systematically evaluated at University of Chicago (now UCSF) and at 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

The evidence Base for family therapy for Anorexia Nervosa

Randomised Controlled trials (RCT's):

Latest update

- 12 RCT's including adolescents.
- 8 RCTs on individual therapy
- 11 RCTs on family therapy
- 1 metanalysis

- Family therapy is superior to individual therapy in terms of
 - BMI over 5 years,
 - Restoring menstruation
 - cognitions
- Full recovery is 40-50% v 20% approx with individual therapy
- Family therapy is the recommended first line treatment for anorexia nervosa in adolescents if < 19 and less than 3 years duration
(AACAP, NICE and RANZCP)
- Treatment as usual (TAU) is inferior to family therapy

Family Based Therapy (FBT) versus systemic family therapy (SFT) for Anorexia Nervosa

No difference in outcome BMI, but..

- * FBT is associated with:
 - * Quicker weight restoration and faster physical recovery
 - * Fewer hospital days
 - * Lower treatment costs
- * SFT may be more effective with comorbid OCD
(Locke et al, 2006, 2010)

Strong evidence that
Early weight gain is crucial in
AN

Research studies to date

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)

Begin with the end in sight: - early weight gain is predictive and crucial

- Early Weight Gain and Outcome research
 - 2 studies
 - FBT (N=65); FBT and AFT (N=121)
 - Results:
 - 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.



Dissemination Effects of FBT 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).

Starting with training in
the key evidence based
treatments

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For adolescent anorexia nervosa this is FBT training-

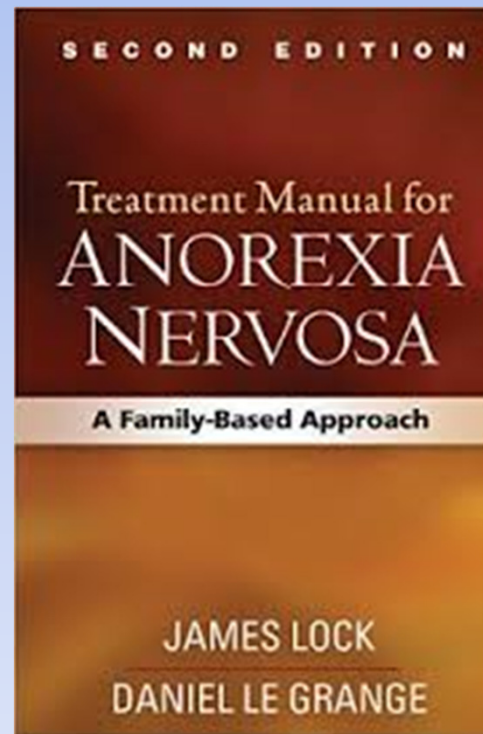
- -71 CAMHS community clinicians completed 2 day core training with Prof Lock in 2015, (plans for another cohort in 2017)
- Currently engaging with development of FBT supervision groups/ supervision framework
- FBT day April 2016

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FBT in the treatment context



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Ethos:

Family Based Therapy FBT (Lock & Le Grange, 2013)

- The family is viewed as the patient's best resource in recovery
- Parents are tasked with taking charge of re-nourishing their starving child.
- Therapist stance is active and aims to mobilise parents' anxiety so that they will effect change in a crisis situation
- Emphasis initially is on behavioral recovery rather than insight and understanding or cognitive change



Indications for use of FBT

- Appropriate as first line treatment for children and adolescents with anorexia nervosa who are medically stable
- Outpatient intervention designed to
 - a) restore weight
 - b) put adolescent development back on track
- A structured, manualised format of delivering family therapy for anorexia nervosa
- Brief hospitalization is some times used to resolve medical concerns

FBT: the treatment 'team'

(FBT treatment manual)



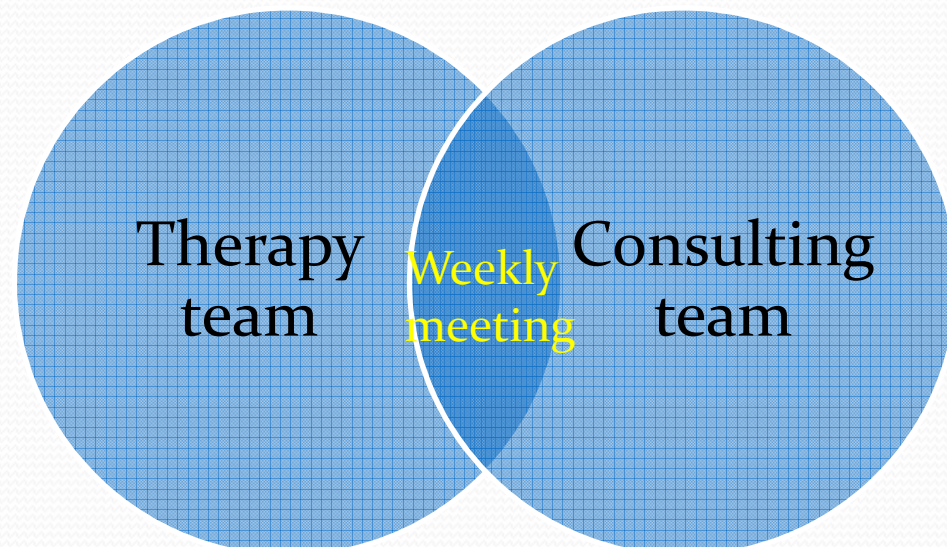
FBT therapy team

'Qualified therapists who have experience in the assessment and treatment of eating disorders in adolescence'

- Lock and le Grange e.g. :
 - Primary clinician/ team lead
 - Child and adolescent psychiatrist
 - Psychologist
 - Social worker
 - Co therapist

Consulting team

- * Paediatrician
- * Nurse
- * Nutritionist/ dietician



The importance of Physical exam and monitoring

- Patients undergo a comprehensive physical examination with a detailed laboratory assessment.
- Differentiating between physical and psychological causes of weight loss is via careful history taking and physical examination with appropriate investigations.
- The commonest co-morbid diagnosis is gastro-oesophageal reflux, particularly in association with functional dysphagia (Nicholls et al 2002).
- With children and adolescents weight, height, and BMI should be re-assessed regularly and plotted on appropriate growth charts.-
- Wt for Ht BMI centile is the most accurate way of determining physical risk in under 18's (BMI alone unreliable)
- Weight targets increase with age. Static weight is equivalent to weight loss in under 18's. Watch for Growth Stunting

Five Fundamental assumptions of FBT

1. Agnostic view of cause of illness
2. Non authoritarian therapeutic stance
3. Parents are responsible for weight restoration
4. Externalization
5. Initial focus on symptoms



1. Agnostic View

- No blame (but this does not mean no responsibility)
- No guilt (but this 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 the treatment)



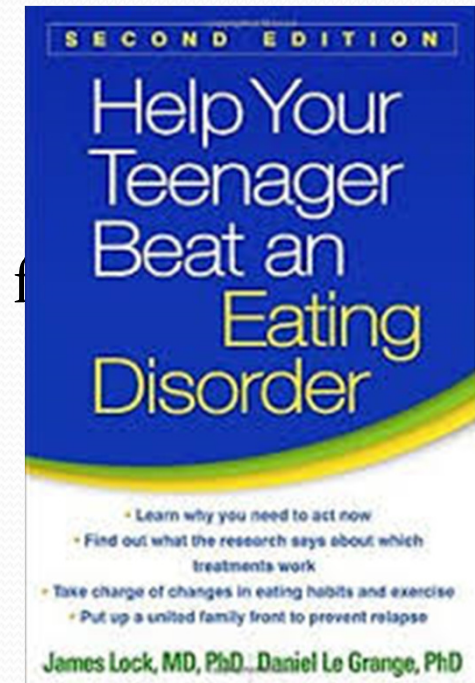
2. Therapeutic Stance

- the therapist serves as expert consultant not the expert in this case
- 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



3. Parental Empowerment

- The family, including siblings, is a resource for 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



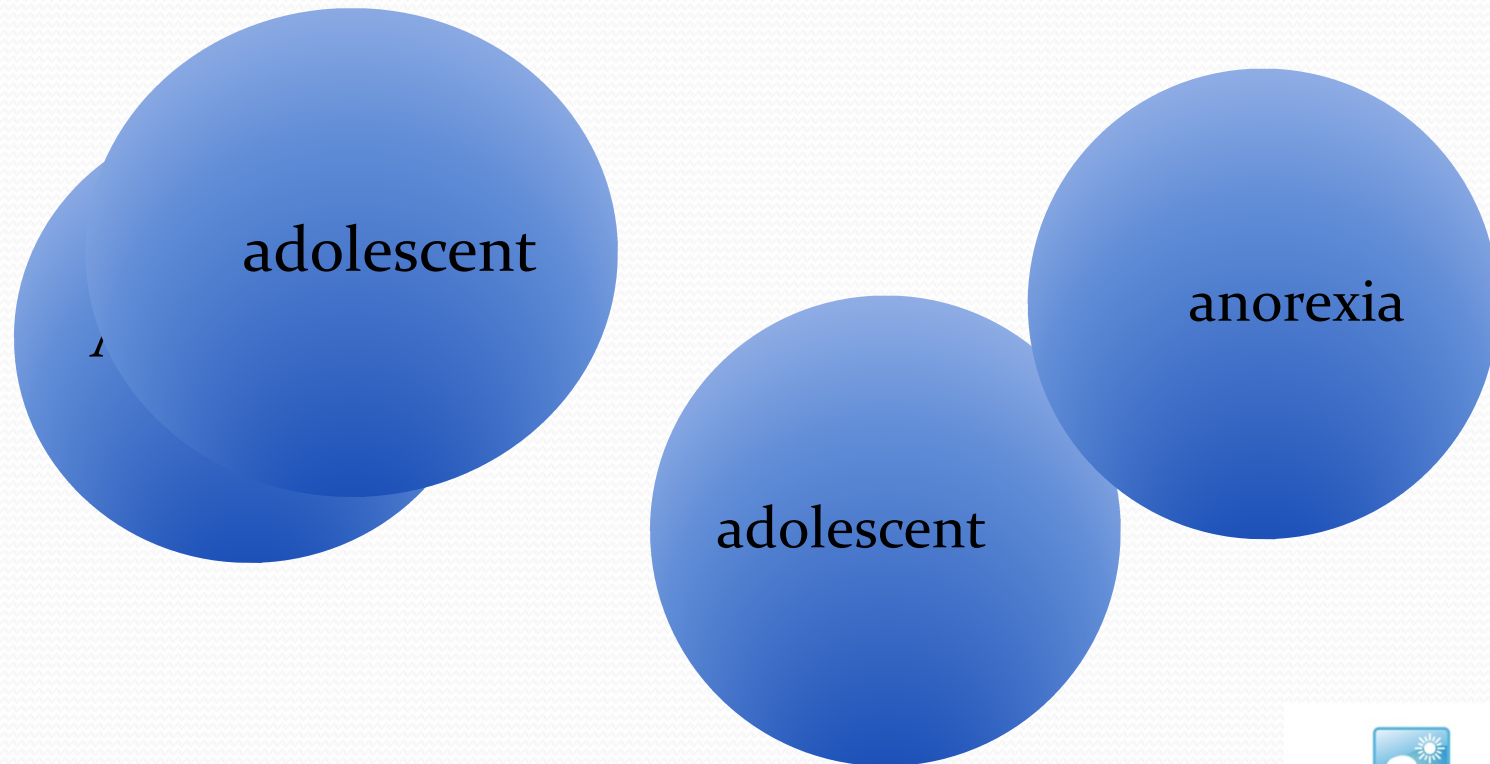
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4. Separation of illness from adolescent (“Externalization”)

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



Person v anorexia



5. Initial Symptom Focus

- Emphasis is first on behavioral change
- History-taking focuses on eating disorder symptom development
- There is a delay of other issues until patient is less behaviorally and psychologically involved with ED
- There is no direct focus on cognitive symptoms of the ED

Focus on eating and gaining weight



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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 Structure

Dose

- 6-12 months

Intensity

- 10-20 sessions

Format

- Conjoint
- Separated



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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



Setting up Treatment



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Core Eating Disorder Evaluation

- Interview with the adolescent
 - Standardised measures (for clinical programme, to be confirmed - see Lock, 2015)
 - Rule in/out comorbidity
 - ED focus
- Interview with the parents
- Medical and risk 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



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



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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



Session Two: The Family Meal

Major Goals of session

- Assess family structure - 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

Interventions in session

- Weigh the patient
- Take a history, observe 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: 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



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



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Phase III (Sessions 17-20): Tracking Back to Normal 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 3: Review of Adolescent Development

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



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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



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Thank You!



Questions?

