Parents-only therapy may be optimal in treating adolescent anorexia nervosa

June 8, 2016 - 12:50pm


Family therapy for 12- to 18-year-olds with anorexia nervosa, in which all household members participate and a meal is held in the clinician’s office, may be less effective than a streamlined model involving only the parents and without the family meal.

Daniel Le Grange, PhD [4]

In a study published online in the Journal of the American Academy of Child & Adolescent Psychiatry [5], 107 adolescents with anorexia nervosa were randomized to two groups: those patients undergoing therapy with their family (family-based treatment or FBT), and those whose parents alone had the counseling while they received "supportive oversight" from a nurse (parent-focused treatment or PFT).
The goal of both treatment models was to try to assist the parents to support their child toward nutritional rehabilitation and weight restoration, said lead author Daniel Le Grange, PhD, Benioff UCSF Professor in Children’s Health in the Departments of Psychiatry and Pediatrics and UCSF Eating Disorders Program director in the Department of Psychiatry and UCSF Weill Institute of Neurosciences.

Both treatments tested in this study entailed guiding the parents to take full control of food intake and transitioning that control back to their child as they developed healthier eating habits and gained weight, said Le Grange, who was working with colleagues at the University of Melbourne, Australia, and is professor emeritus at the University of Chicago.

One significant difference in the treatment models was that in the parents group (PFT), there was no meal in the clinician’s office, an intervention considered critical in the conjoint family model (FBT). Instead the clinician focused almost exclusively on helping the parents manage the illness in the therapy sessions. It would seem that a clinical intervention (the family meal) heretofore considered critical for successful outcome in treatment, might after all not be quite as necessary, said Le Grange.

Both FBT and PFT comprised 18 outpatient sessions over six months at the Royal Children’s Hospital in Melbourne, Australia. Most patients were female (88 percent), the average age was 15, and all patients met the diagnostic criteria for anorexia nervosa.

When treatment ended, 43 percent of the adolescents whose parents had participated in counseling (PFT) had reached remission, defined as attaining a normal or near-normal weight and showing healthy thinking about eating. In contrast, 22 percent of the adolescents who had participated in the conjoint family model (FBT) achieved remission.

Remission rates started to converge six months after treatment, dipping to 39 percent in PFT and remaining at 22 percent in FBT. This trend continued at 12 months, at 37 percent and 29 percent respectively, suggesting that the differences in effectiveness between the two models might be less pronounced in the long term.

What we have learned is that both models are equally effective in patients with a high degree of eating disorder-related obsessions and compulsions, such as rituals and other behaviors around calories and forbidden foods, and those whose psychopathology meant they judged themselves entirely by the number on the scale, said Le Grange.

But in patients with a relatively low level of obsessions and compulsions and psychopathology, patients did much better if therapy was limited to the parents, he said.

It could be that the parent-only model enables parents and the clinician to spend the full therapy session on developing strategies that help them support their child. In the conjoint family model, a tremendous amount of effort on the part of the patient is spent on derailing the discussion, and a tremendous effort on the part on the clinician is spent to keep the discussion on track.

Of note, the researchers found that patients were more likely to achieve remission at 12 months after treatment if their fathers did not demonstrate high expressed emotion, such as over-involvement with the child, hostility and criticism traits that have already been identified as deleterious in the treatment of eating disorders.
The take-home message is that a parents-only model is as good if not better than the conjoint family model, and it provides us with an intervention than might be easier to implement and disseminate. This may be an issue in clinicians without formal family therapy training, who are hesitant to work in a format that includes the patient, parents, other caregivers and siblings, noted Le Grange.

The study was supported by funding from the Baker Foundation (Australia).

Co-lead author was Susan Sawyer, FRACP, MD, from the University of Melbourne, Centre for Adolescent Health, Royal Children?s Hospital, and Murdoch Children?s Research Institute in Australia. Co-authors were Elizabeth Hughes, PhD, from the University of Melbourne and Murdoch Children?s Research Institute, in Australia; Andrew Court, MBBS, FRANZP, and Michele Yeo, FRACP, PhD, both from the Centre for Adolescent Health, Royal Children?s Hospital in Australia; and Ross Crosby, PhD, from the Neuropsychiatric Research Institute and University of North Dakota School of Medicine and Health Sciences, both in Fargo.

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