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# A thorn in the side of evidence-based treatment for adolescent anorexia nervosa

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Anorexia nervosa (AN) is amongst the most pernicious of psychiatric illnesses, demonstrating an average duration of seven years and mortality rates of up to 20% (Steinhausen, 2002). The treatment of AN is best undertaken with early intervention, which has resulted in treatment interventions targeting adolescent presentations of AN. Currently, the gold standard evidence-based treatment of adolescent AN is family based treatment (FBT), which is a specific manualised form of eating disorder focussed family therapy (Lock et al., 2001). However, an emerging research-practice gap within the eating disorder field (Strober and Johnson, 2012; Waller, 2009) may be particularly relevant to FBT, potentially limiting the application and efficacy of this treatment.

FBT is characterised by an agnostic stance towards the origin of AN, and conceptualises parents as experts in feeding their children. This is predicated on the notion that parents know how to feed a healthy child (as is usually evidenced by the absence of AN in their child's earlier years), but posits that the presence of the AN can be so overwhelming within the family so as to coerce parents away from their natural instincts, resulting in a level of accommodation to AN symptoms. Thus, treatment is initially focused on utilising parental strengths in providing nutritional rehabilitation for their child, which takes undivided precedence over other areas of adolescent functioning. The magnitude of the medical crisis potentially facing their child necessitates swift and

direct parental intervention, and as such parents are encouraged to exercise full control over all ecological and individual maintaining factors of AN until they are abated, whilst their child is supported by siblings. Subsequent to weight gain and a decline in AN symptomatology, age-appropriate autonomy and independence is restored to the child, who may begin to demonstrate more control over food and eating. The final stage of treatment focuses less on food specifically, and more on general adolescent issues which may include individuation and separation, anxiety, depression and social integration.

A recent Cochrane review concluded that FBT may be effective compared to treatment as usual in the short term, although there is currently an insufficient number of clinical trials establishing FBT as significantly efficacious over other credible forms of treatment in the long term (Fisher et al., 2010). However, over the last 25 years FBT has developed as an increasingly promising empirically validated treatment supported by randomised control trials, open trials and dissemination studies in the UK, USA, Canada, Sweden and Australia (Couturier et al., 2010; Eisler et al., 2000; Loeb et al., 2007; Paulson-Karlsson et al., 2009). Recent empirical evidence demonstrates promising outcome data for FBT, such that up to 80% of adolescent cases of AN treated with FBT are weight restored within 12 months, and up to 90% remain weight restored after five years (Lock et al., 2006).

Furthermore, up to 40% are remitted of eating disordered cognitions and behaviours by the end of treatment, which compares favourably with other forms of adolescent-oriented treatment. These typically demonstrate approximately 22% remission of cognitive eating disorder symptomatology and 66% weight restoration (Lock et al., 2006). In Australia, FBT has been shown to reduce the rate of hospital readmissions by up to 50% (Wallis et al., 2007). In going some way to addressing concerns over the lack of credible comparison trials, a recent randomized control trial documented that, as compared to adolescent focused individual therapy, FBT is characterised by fewer in-patient hospital admissions, faster rates of full remission and weight restoration, and fewer rates of relapse (Lock et al., 2010). As such, both the National Institute of Clinical Excellence and the Academy of Eating Disorders guidelines currently support familial involvement in treatment interventions (Le Grange et al., 2010).

However, despite such promising outcome data, family based treatment of AN is not without its challenges. This treatment is typically

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characterised by high levels of parental anxiety, which is mobilised in facilitating parental interventions to curb their child's behavioural symptoms. Although highly effective, this course of treatment may be experienced as unpleasant by parents and adolescents alike (Parent and Parent, 2008), as parents are often required to make significant sacrifices in temporarily preparing and supervising all meals in addition to exercising firm boundaries regarding the 'tricks' of AN, whereas many adolescents describe the degree of parental control exercised as restrictive and age-inappropriate. This family based approach, and in particular the efficacy and expertise attributed to parents in re-feeding their child, contrasts markedly with earlier approaches to the treatment of adolescent AN which was seen as a disorder of individuation (Smolak and Levine, 1993). This contrasting theory postulates that family characteristics are implicated in the aetiology of AN, advocating a 'parentectomy' to help the adolescent individuate from their 'anorexogenic' family. Despite developmentally informed empirical research refuting any causal role of the family in AN (Jacobi et al., 2004), demonstrating that families with an anorexic child function closer to controls than other psychiatric groups (North Gower and Byram, 1995) and that no particular family style is implicated in the development of AN (Eisler, 1995), for many clinicians this empirical research has had limited effect on their beliefs and is not reflected in their clinical practice (Tobin et al., 2007; Waller, 2009).

Such antonymic approaches to treatment in a population with a high propensity for splitting behaviours (Lyon et al., 2005) may pose significant challenges to the effective outpatient treatment of adolescent AN when managed across multidisciplinary teams involving different service providers. Parental anxiety and the often disempowered nature of parents facing AN (Rhodes, 2003)

may mean that clinicians are frequently invited to endorse other, less challenging forms of treatment which don't require family involvement. However, empowering the actively symptomatic adolescent towards individuation may contraindicate attempts to empower parental control. This is particularly worrisome in light of recent empirical data illustrating that parental control is the single most effective predictor of illness remission amongst adolescents in FBT (Ellison et al., 2012). A further challenge facing the FBT practitioner may be a common assumption amongst some multidisciplinary team members that FBT is not effective for mature adolescents. Whilst FBT significantly improves symptomatology in up to 80% of cases (leaving 20% whose symptoms do not remit with this treatment), emerging empirical data regarding the moderators and mediators of this treatment do not support the notion that adolescent maturity impinges upon treatment (Le Grange et al., 2012).

Thus, one significant challenge facing multidisciplinary teams managing adolescent AN lies in maintaining consistency across all its members. One member of a multi-disciplinary team admonishing the use of FBT in attempting to alleviate parental anxiety or empower mature adolescent individuation may undermine the primary agent of change in FBT. This model of treatment implores parental unity and consistency in overcoming AN, although perhaps an overlooked parallel requirement is the necessity for similar consistency and unity amongst professionals. Thus despite its promising evidence base, FBT is likely underutilised in clinical practice due to the considerable challenge of aligning theoretical orientations across multidisciplinary teams comprising differing theoretical and occupational standpoints, and frequent and transparent communication is essential. The scope for FBT being undermined is perhaps greater than individual forms

of treatment, which in conjunction with elevated levels of patient discomfort, underscores the need for a united and consistent treatment team who are committed to providing the gold standard treatment.

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### References

- Couturier J, Isserlin L and Lock J (2010) Family-based treatment for adolescents with anorexia nervosa: a dissemination study. *Eating Disorders* 18: 199–209.
- Eisler I (1995) Family models of eating disorders. In Szmukler G I, Dare C and Treasure J (eds) *Handbook of Eating Disorders: Theory, Treatment and Research*. London: John Wiley & Sons.
- Eisler I, Dare C, Hodes M, et al. (2000) Family Therapy for Adolescent Anorexia Nervosa: The Results of a Controlled Comparison of Two Family Interventions. *Journal of Child Psychology & Psychiatry* 41: 727–736.
- Ellison R, Rhodes P, Madden S, et al. (2012). Do the components of manualised family-based treatment for anorexia nervosa predict weight gain? *International Journal of Eating Disorders* 45: 609–614.
- Fisher CA, Hetrick SE and Rushford N (2010) Family therapy for anorexia nervosa. *The Cochrane Library* 6.
- Jacobi C, Hayward C, De Zwaan M, et al. (2004) Coming to terms with risk factors for eating disorders: Application of risk terminology and suggestions for a general taxonomy. *Psychological Bulletin* 130:19–65.
- Le Grange D, Lock J, Agras WS, et al. (2012) Moderators and mediators of remission in family-based treatment and adolescent focused therapy for anorexia nervosa. *Behaviour Research and Therapy* 50: 85–92.
- Le Grange D, Lock J, Loeb K, et al. (2010) Academy for eating disorders position paper: The role of the family in eating disorders. *International Journal of Eating Disorders* 43: 1–5.
- Lock J, Couturier J and Agras WS (2006) Comparison of long term outcomes in adolescents with anorexia nervosa treated with family therapy. *American Journal of Child & Adolescent Psychiatry* 45: 666–672.

- Lock J, Le Grange D, Agras WS, et al. (2001) *Treatment manual for anorexia nervosa: a family-based approach*. New York: Guilford Press.
- Lock J, Le Grange D, Agras WS, et al. (2010) Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Archives of General Psychiatry* 67: 1025–1032.
- Loeb KL, Walsh BT, Lock J, et al. (2007). Open trial of family-based treatment for full and partial anorexia nervosa in adolescence: Evidence of successful dissemination. *Journal of the American Academy of Child & Adolescent Psychiatry* 46: 792–800.
- Lyon ME, Silber TJ and Atkins D (2005) Process, promise, and pitfalls of collaborative treatment of anorexia nervosa in an adolescent patient. *Clinical Case Studies* 4: 189–204.
- North C, Gowers S and Byram V (1997) Family functioning and life events in the outcome of adolescent anorexia. *British Journal of Psychiatry* 171: 545–549.
- Parent BA and Parent TC (2008) Anorexia, Maudsley and an impressive recovery: One family's story. *Journal of Paediatrics and Child Health* 44: 70–73.
- Paulson-Karlsson G, Engström I and Nevenon L (2009) A pilot study of a family-based treatment for adolescent anorexia nervosa: 18- and 36-month follow-ups. *Eating Disorders* 17: 72–88.
- Rhodes P (2003) The Maudsley model of family therapy for children and adolescents with anorexia nervosa: Theory, clinical practice, and empirical support. *Australian & New Zealand Journal of Family Therapy* 24: 191–198.
- Smolak L and Levine MP (1993) Separation-individuation difficulties and the distinction between bulimia nervosa and anorexia nervosa in college women. *International Journal of Eating Disorders* 14: 33–41.
- Steinhausen HC (2002) The outcome of anorexia nervosa in the 20th Century. *American Journal of Psychiatry* 159: 1284–1293.
- Strober M and Johnson C (2012) The need for complex ideas in anorexia nervosa: Why biology, environment, and psyche all matter, why therapists make mistakes, and why clinical benchmarks are needed for managing weight correction. *International Journal of Eating Disorders* 45: 155–178.
- Tobin DL, Banker JD, Weisberg L, et al. (2007) I know what you did last summer (and it wasn't CBT): A factor analytic model of international psychotherapeutic practice in the eating disorders. *International Journal of Eating Disorders* 40: 754–757.
- Waller G (2009) Evidence-based treatment and therapist drift. *Behaviour Research and Therapy* 2: 119–127
- Wallis A, Rhodes P, Kohn M, et al. (2007) Five-years of family based treatment of anorexia nervosa: The Maudsley model at the Children's Hospital at Westmead. *International Journal of Adolescent Medicine and Health* 19: 277–283.