Indexing psychopathology throughout family-based treatment for adolescent anorexia nervosa: are we on track?

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Indexing psychopathology throughout family-based treatment for adolescent anorexia nervosa: are we on track?

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Anorexia nervosa (AN) is amongst the most severe of all psychiatric illnesses, demonstrating an average duration of 7 years and mortality rates of up to 20% in adults (Steinhausen, 2002). As such, the treatment of AN is best undertaken with early intervention, which has resulted in treatment interventions targeting adolescent presentations of AN, which is the most common period of onset for AN. Currently, the leading evidence-based treatment of adolescent presentations of AN is family-based treatment (FBT), which is a specific manualised form of eating disorder-focussed family therapy (Lock & Le Grange, 2013).

This particular treatment is characterised by an agnostic stance towards the origin of AN, and a conceptualisation of parents as the primary resource in weight restoring their ill adolescent. FBT adopts the notion that many parents instinctively know how to feed a healthy child, but posits that the presence of the AN can be so overwhelming within families that it coerces parents away from their natural instincts, inadvertently resulting in a level of accommodation to AN symptoms. Treatment is, therefore, initially focussed on utilising parental strengths in ensuring nutritional rehabilitation for their child. This takes undivided precedence over other areas of adolescent functioning, and typically involves parents temporarily adopting full control over all ecological and individual maintaining features of AN until they are abated. Subsequent to weight gain and a decline in AN symptoms, age-appropriate autonomy and independence may be gradually 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.

Empirical evidence continues to generate support for FBT, illustrating that up to 80% of adolescents are weight restored within 12 months, and up to 90% remain weight restored after 5 years (Lock, Couturier, & Agras, 2006). Furthermore, up to 40% are free of eating disordered cognitions and behaviours by the end of treatment, reporting Eating Disorder Examination

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(Fairburn & Cooper, 1993) scores within one standard deviation of community norms. This compares favourably with other forms of adolescent-oriented treatment (Lock et al., 2010). As such, both the National Institute of Clinical Excellence and the Academy of Eating Disorders guidelines currently support family involvement in treatment interventions (Le Grange, Lock, Loeb, & Nicholls, 2010). However, a significant minority of adolescents do not benefit from FBT (Fisher, Hetrick, & Rushford, 2010), and ongoing research has called for further investigations into the efficacy of FBT, with some arguing against ‘being tyrannised by the evidence’ supporting FBT (Hay, 2012).

Thus, throughout FBT many adolescents are placed in the inextricable position of facing the intense fear of weight gain which is inherent to AN, whilst simultaneously being required by their parents to gain weight quickly to offset any potential medical consequences of AN. As a result, many adolescents with AN are coerced into resolving this dilemma by adopting ‘sneaky tricks’ which may conceal AN behaviours, giving the impression of reduced symptom severity, thus deceiving their parents into adopting less firm interventions. For instance, reports of falsifying one’s weight during the course of FBT abound (Poser, 2005), and although this likely reflects an escalating level of distress around gaining weight (and, therefore, the need for greater parental intervention), the effect of an apparently increasing weight may reassure parents into adopting less firm strategies around symptom intervention. In this sense, many adolescent responses during the early stages of FBT are often skewed towards wanting to appear ‘more recovered’ than they may be, so as to dissuade parents away from further parental control. As a result, many FBT practitioners lend more credence to parental reports of disordered eating in their child rather than what is reported by adolescents themselves.

However, in light of this notion, one particular inconsistency involves the indexing of symptomatology in both clinical practice and research trials, which to date has largely relied on adolescent self-disclosure. Should adolescents be coerced into adopting similar deceptive practices in completing self-report inventories of cognitive and behavioural symptom severity, a murky picture of one’s symptom profile may emerge which would be likely to facilitate Type II errors and the under-detecting of symptom severity in research trials.

One possible alternative would be a shift towards relying on parents themselves to disclose their own observations of their child’s psychopathology, in a similar manner to those utilised in other adolescent populations such as the Strengths and Difficulties Questionnaire (Goodman, 1997), which index parental observations in addition to their child’s disclosures. To date few attempts have been made to integrate parental reports of disordered eating behaviours into empirical research exploring the efficacy of FBT. This is despite FBT emphasising the role of parents as experts in detecting and overcoming disordered eating symptomatology in their children (Lock & Le Grange, 2013) and the noted propensity for inaccurate symptom disclosure from adolescents with AN. For instance, one particular study compared the self-report version of the EDE-Q (Fairburn & Beglin, 1994) with the clinician administered EDE interview (Cooper & Fairburn, 1987) in adolescents with AN, noting significant differences in many subscales (Berg, Peterson, & Frazier, 2012; Passi, Bryson, & Lock, 2003). However, both the interview and self-report versions are dependent on accurate information disclosure by the adolescent, and therefore may be equally vulnerable to the under-reporting of symptom severity. Perhaps further underscoring this need to index and account for parental observations of their child’s pathology, a recent comparison noted widely differing reports of psychopathology between parents and adolescents with eating disorders (Brown, Loeb, Craigen, Munk Goldstein, & Fairburn, 2010; Loeb et al., 2009).

Thus, research evaluating the efficacy of FBT based on the adolescent’s ability to disclose accurately their cognitive and behavioural symptom profile may be inherently imperfect. It is likely that the ego-syntonicity of AN, and a developing awareness throughout FBT that
symptom disclosure may lead to increasingly firm parental interventions, may make symptom disclosure exceedingly difficult for the adolescent. Indeed, one of the underlying tenets of FBT posits that the presence of AN is often too strong for adolescents to manage alone, hence necessitating familial involvement. In this sense, the possible non-disclosure of ego-syntonic symptoms may also form part of the constellation of symptoms better accounted for by parental authority. With ongoing calls for the further investigation of the efficacy of FBT (Fisher et al., 2010), a crucial endeavour may be the development of methods of indexing parental reports of their adolescent’s symptomatology, which may offer crucial data alongside adolescent’s own reports.

Where to from here?

Indexing parental observations of disordered eating in their child, alongside the self-reports of adolescents, may allow for a more comprehensive and multifaceted testimony to one’s symptom profile, in addition to highlighting important clinical data for the FBT clinician. For instance, a large discrepancy between parental and adolescent reports of eating disordered symptomatology may highlight the child’s cognitive attachment to the illness in being coerced into the attempted under-reporting of their symptoms. Equally it may reflect parental anxiety and the potential over-reporting of normative adolescent behaviours, which are not immediately attributable to their child’s illness, both of which would be crucial to address throughout treatment. Thus, the development of a measure to index parental reports alongside adolescent self-reports may be crucial in augmenting the integrity of research trials investigating the efficacy of FBT, and may also offer important clinical data to FBT clinicians throughout the treatment.

To this end, recent endeavours have attempted to modify existing eating disorder measures to accommodate parental observations of eating behaviours and attitudes. For instance, both the EDE (Cooper & Fairburn, 1987) and the EDE-Q (Fairburn & Beglin, 1994) were recently modified and oriented towards parental observations of their child’s eating disorder pathology (Loeb, 2007, 2008; Loeb, Brown, & Goldstein, 2011). Preliminary results indicate discrepancies between child and parent report, with parents endorsing greater levels of pathology in their child, that carry significant implications for case identification efforts (Brown et al., 2010; Loeb et al., 2009). Such measures, which although currently awaiting tests of reliability and validity, may move towards addressing the deficiencies in our field in assessing the eating disorder pathology of adolescents in FBT. They may also lie in accordance with broader changes to be introduced in DSM-5, which allow for more behavioural indicants of the psychological features of AN (Bravender et al., 2011). Thus, we recommend that future research trials adopt measures which index parental reports of their child’s eating disorder pathology.

References


