The Society for Clinical Child and Adolescent Psychology (SCCAP): Initiative for Dissemination of Evidence-based Treatments for Childhood and Adolescent Mental Health Problems

With additional support from Florida International University and The Children’s Trust.
Keynote
Evidence-Based Treatment for Adolescents with Anorexia and Bulimia

Daniel Le Grange, Ph.D.
Director: Eating Disorders Clinic
Professor of Psychiatry and Behavioral Neuroscience
The University of Chicago Medical Center
Outline of Presentation

① The role of the family in eating disorders

② Evidence-based treatment for AN
   ➢ Implications of findings

③ Evidence-based treatment for BN
   ➢ Implications of findings

④ Resources and current studies
The Role of the Family

Adolescent Anorexia Nervosa

Le Grange et al., IJED, 2010
“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)
“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.”

“In view of the undoubted psychological aspects (of the disorder), it would be equally regrettable to ignore or misinterpret the patient’s psychological surroundings.”
“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.”  

Second Half - Salvador Minuchin, Child Psychiatrist and parent of Structural Family Therapy

*MedicineNet.com
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.
Part 2

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.
Summary of these five studies

- 5 RCTs comparing psychosocial treatments for adolescents with AN
- 4 of these involve family therapy (FBT or BFST)
- 3 of these involve individual therapy (supportive, adolescent focused therapy, CBT)
- Evidence supports effectiveness of FBT, but comparative efficacy data is limited
Family-Based Treatment vs Adolescent Focused Therapy for adolescent anorexia nervosa

A multisite comparison

Lock, Le Grange, Agras, Moye, Bryson & Jo, Arch Gen Psych, 2010
Rationale

The predominant models for treating adolescent AN are:

- **Family-Based Treatment (FBT)** is a therapy aimed at symptom management by parents early in treatment

- **Adolescent Focused Therapy (AFT)** is a therapy aimed at promoting self-efficacy, self-esteem, and self-management of eating problems by the adolescents
Study Design

Chicago (Le Grange)

Assessors & Therapists

Stanford (Lock)

Assessors & Therapists

DCC (Agras)
Study Design

- FBT > AFT in promoting full + partial remission; Meds will moderate outcome
- Randomized 121 med stable adolescent AN (excl amenorrhea) to FBT or AFT; 2 mo on stable meds dose still meeting entry criteria
- 12 mo (24 contact hrs) of tx (24-1 hr sessions in FBT & 32-45 min sessions in AFT including collaterals with parents alone)
- Independent assessments of weight + EDE at BL, EOT, 6 and 12 month
Primary Outcome

Full remission, i.e., 95% IBW for height and age according to CDC norms + EDE within 1SD of community norms

- Approximates weight needed for return to full physical health in young adolescents and addresses growth, bone health, and hormonal function
- EDE threshold is in the normal range for community sample and addresses minimization common in adolescent AN
Remitted at 3 months

- Fisher's Exact $p = .021$

Bar chart showing percentages of remitted at 3 months.
Observed Partial and Full Remission by Treatment

- **AFT**
  - EOT: 17
  - 6m followup: 13
  - 12m followup: 13
- **FBT**
  - EOT: 5
  - 6m followup: 7
  - 12m followup: 10

Legend:
- Not remitted
- Partial remission
- Full remission
Time until %-IBW > 95%
Relapse: Post-Treatment to 12-Month Follow-Up

![Bar chart showing relapse at 12-month follow-up]

- **Fisher's Exact p = 0.021**
- Relapse at 12 mo FU

- FBT: 10
- AFT: 45
Summary Findings

- 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.
- More participants treated with FBT reached weight restoration by 3 months 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*

Pre | Post
---|---
16.5 | 17
17 | 17.5
18 | 18.5
19 | 19
19.5 | 19.5

*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

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)]

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
Part 3

Evidence-Based Treatment

Adolescent Bulimia Nervosa
Chicago RCT
FBT-BN vs SPT

- N=80 adolescent BN
- FBT-BN n = 41
- SPT n = 39
- 6 months of therapy
- 6 month follow-up

Le Grange, Crosby, Rathuaz & Leventhal,
Arch Gen Psych, 2007.
Conclusions

- Family-based treatment showed a clinical and statistical advantage over SPT at post-treatment and at 6-month follow-up.

- Reduction in core bulimic symptoms was also more immediate for patients receiving FBT vs SPT.
Maudsley RCT
FBT vs CBT-GSC

- N = 85 adolescent BN
- Family Therapy n = 41
- CBT-GSC n = 44
- 6 months of therapy
- 6 month follow-up

Conclusions

- Compared with family therapy, CBT guided self-care has the slight advantage of offering a more rapid reduction of bingeing, lower cost, and greater acceptability for adolescents with bulimia or eating disorder not otherwise specified.
Summary Findings

- Significantly greater early reductions in symptomatic behavior for patients in FBT-BN than in SPT
- Significantly more patients in FBT-BN than in SPT remitted at EOT and FU
- No differences between FBT-BN and CBT-GSC, although CBT more cost effective
- 40% remitted at EOT is still just a “foot in the door”
Implications for BN

- FBT and CBT for adolescents with BN are promising

- Further work is required
  - Type of family involvement
  - CBT with parental support for adolescent BN
  - Role of medication
Resources and Current Studies

Adolescent Anorexia and Bulimia Nervosa
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)

- Clinician Manuals available for CBT-BN, AFT-AN and SPT (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 (Chicago & Mt Sinai, NY)
- 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)
For more information, please go to the main website and browse for workshops on this topic or check out our additional resources.

**Additional Resources**

**Online resources:**
1. SCCAP: Society of Clinical Child & Adolescent Psychology: https://clinicalchildpsychology.org

**Books:**

**Peer-reviewed Journal Articles:**
Keynote: Evidence-Based Treatment for Adolescent Eating Disorders

Books:

Case Descriptions:

Peer Reviewed Journal Articles:


