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Family-Based Treatment of an Adolescent with Anorexia Nervosa Living in a
Group Home: Case Report

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Abstract

We investigated the efficacy of family-based therapy (FBT) in treating an adolescent male diagnosed with anorexia nervosa (AN) living in a group home. The patient was seen for 13 sessions over the course of 9 months using standardized FBT-AN. Two staff members agreed to act as 'parents' for the patient. Weight was assessed at each session and again at 6-month post treatment follow-up. The patient presented at the first visit with a weight of 99.1 pounds [76% ideal body weight (IBW) for his age and height]. Over the course of treatment, the patient's weight increased a total of 16 pounds placing him at the 87% IBW. At the 6 month follow-up, the patient weighed 112 pounds placing him at 81.5% IBW. Findings suggest that FBT-AN can be effectively utilized in non-traditional settings. More data is needed on the applicability of this method in non-traditional family settings, particularly over the long term.

Keywords: anorexia nervosa, Maudsley-based family therapy, eating disorder treatment, case series, family-based therapy

Family-Based Treatment of an Adolescent with Anorexia Nervosa Living in a Group Home: Case Report

Anorexia nervosa (AN) is a serious and debilitating disease with the highest death rates of any psychiatric illness. Given these dire statistics, interventions for this population are in high demand. Thus far, adult and adolescent behavioral treatments available (e.g., CBT, ACT, Supportive, Dynamic, Nutritional counseling) have been largely ineffective . Results from the few published randomized clinical trials have been plagued with high drop-out and low remission rates, especially for those with longer duration of illness .

Within the last decade, guided by the recommendation of an expert panel , researchers have begun to focus more exclusively on developing treatments for adolescents with AN. One family-based treatment for AN, often referred to as the “Maudsley method” or FBT-AN , has shown promising results with adolescents and is currently recommended as the front-line treatment for adolescents with AN . Current research from these trials

indicates that FBT-AN is effective for 80-90% of adolescents , and is superior to both individual and supportive psychotherapy .

A full manual for FBT-AN has been published elsewhere . Briefly, FBT-AN is divided into 3 phases and is typically completed within a 6-12 month period. As a tenet, therapy is conducted with the entire family and at its core is focused around 1) mobilizing the family to fight AN and 2) teaching the parents how to re-feed their starving offspring.

During the first phase, central elements include educating the family about the dangers of severe malnutrition and enlisting the parents to help the child begin eating again. The primary goal of this phase is to keep the family focused on the eating disorder and in particular, weight gain. The family is taught to view AN as a disease that is attacking their child (i.e., disparate from the child rather than a part of him/her). Siblings are aligned with the patient and a parental alliance is formed around re-feeding (i.e., returning the adolescent to a medically stable weight). One particularly unique feature of FBT-AN is an in-session family meal that is used to provide the therapist with objective information about the family dynamics during meals and to provide in vivo parental coaching on how to have their child eat more than he/she is prepared to. Phase 1 continues until the adolescent is able to eat on his/her own and has made steady gains in weight (typically this transition occurs when the IBW returns to approximately 90%).

In Phase 2, the primary goal is to have the parents transition their authority over the adolescent's eating back to the adolescent so that ultimately he/she is able to eat independently and maintain a healthy weight. This goal is achieved slowly and cautiously, dependent on the patient's weight and the level of familial anxiety occurring around mealtimes. Once the adolescent is eating independently and a healthy weight seems stable, the final phase of treatment initiates (Phase 3).

In Phase 3, the focus shifts away from weight restoration and moves more towards the impact that AN has had on typical adolescent development. These sessions are tailored to address the particular issues surrounding the adolescent and his/her family (e.g., sexuality, independence, social identity).

In the description of FBT-AN above, the role of the family is unambiguously clear—particularly the function/responsibility of the parent(s). The focus of this report is on the applicability of FBT-AN in a setting in which no parent is available. Specifically, we report on the case of a 16-year-old male with AN living in a group home.

Reason for Referral/ Background Information

The patient (will be referred to as "Sam") was a 16-year-old male living in a group home in the San Diego metro area with a history of drug use and school failure. He was originally placed in foster care at the age of 4 years

due to severe parental neglect. He had been residing in his current placement for approximately three months. Upon arrival, the staff at his residency had become increasingly concerned about his poor appetite and corresponding low body weight and were referred to the UCSD Eating Disorders Treatment Program.

Assessment and Diagnosis

The format of the assessment was unstructured and was focused around Sam's current and past eating behaviors. He arrived for an intake accompanied by a staff member. Diagnosis for AN was determined using criteria established by the Diagnostic and Statistical Manual Fourth Edition . Sam denied experiencing appetite and endorsed a general disinterest in food. He reported feeling uncomfortable after eating (stomach feels "bubbly", "full and growls") and stated that he preferred the feeling of emptiness. He endorsed fears of weight gain (Criterion B: Intense fear of gaining weight or becoming fat, even though underweight), specifically in relation to playing basketball ("If I gain weight I won't be as fast and I will be lazy and tired"). He did not see any problems with his current weight and stated that it was "normal" given his age and height (Criterion C: Denial of the seriousness of the current low body weight). A progress report sent from the group home indicated that Sam had become increasingly isolated and was struggling to eat during meals. The report further noted that Sam was

“extremely picky about the food he ate and almost always had peanut butter and jelly for his meals”.

At this first visit, he was pale and noticeably gaunt. His speech was slow, he rarely made eye contact and he exhibited poor expressive language skills. His weight and height placed him at the 1st percentile and reflected a BMI of 15.6 (76% IBW); per Sam’s report and records from the group home, he had been underweight for as long as he could remember (Criterion A: Refusal to maintain body weight at or above a minimally normal weight for age and height). Given this information, Sam met full DSM-IV diagnostic criteria for AN.

Case Conceptualization and Treatment Planning

Therapy was administered by the first author (VA) with weekly clinical supervision from the second author (KB). Given the treatment literature on adolescents with AN, it was clear that FBT-AN would offer Sam the greatest chance of remission, however, we were unclear of whether it could be administered in a group home setting. The therapist discussed the option with the supervisor from the home and an agreement was made to attempt FBT-AN by appointing two staff members to act as ‘parents’ during the therapy.

Sam and the appointed staff members were seen for a total of 13 50-minute sessions over a 9-month period during the years 2009-2010. Sessions began weekly but were tapered (to bi-weekly, followed by monthly) based on Sam's progress. Sam was in Phase 1 for nine sessions and in Phase 2 for the remaining four. Weight was assessed prior to each session and sessions were terminated once the therapist was no longer available for services (i.e. relocated to another city). Sam was reassessed for AN at a six month follow-up visit.

TREATMENT COURSE

Phase 1 (Sessions 1-9)

At the first session, two staff (will be referred to as "the caregivers") arrived with Sam. They were selected based on the amount of time they spent with him and their shift coverage. One staff member covered the morning shift (female; we will refer to her as "Sarah") and the other covered the afternoon and evening (male; we will refer to him as "Mike"). The caregivers appeared genuinely concerned about Sam and fully engaged in the treatment. Sam appeared indifferent. He read a book for the majority of the session and spoke only when directly asked a question. One of the few comments Sam made was that without AN he would be "fat."

A key goal in the first session of FBT is to charge the parents with the task of re-feeding. In this case, the therapist also needed to discuss the logistics of “parenting” Sam (i.e., focusing on Sam over the other boys at the home). The caregivers planned to sit with him during all meals and to have other staff take over their regular duties at those times. Our second session (the family meal) was delayed by one week because Sam refused to get out bed on the day of our appointment. After receiving some behavioral coaching from the therapist, the caregivers restricted Sam’s privileges and called a house meeting in which they presented him with an ultimatum: attend treatment or go to hospital; Sam decided on the former.

The following week, the caregivers brought hamburgers, French fries and soda to the family meal. Sam ate the hamburger independently but refused to eat the French fries. Once it was clear that Sam was finished eating, the therapist asked the caregivers to encourage him to eat one more bite, a pivotal component of this session. Initially he refused, but after some direct coaching from the therapist (sitting on both sides of him; reminding Sam of the consequences of not eating), the caregivers were successful in getting Sam to finish not just one more bite but, the remainder of his meal. This was a great achievement and likely bolstered confidence the caregivers needed to begin re-feeding Sam at the group home on their own.

Over the first three sessions, Sam’s weight increased steadily by 5 pounds (See Figure 1). However, at the fourth session his weight decreased

by two pounds. Sam and Mike arrived at this session without Sarah. Mike stated that Sarah would no longer be working with Sam and was leaving her job. This significant change had occurred mid-week and as a result, left Sam without morning supervision for several days. Not surprisingly, Sam self-reported fasting until Mike began the afternoon shift (approximately 3pm; “I am always running late for school and forget to eat”). We used the session to brainstorm methods to get Sam to eat in the morning and early afternoon. This task was particularly difficult given that Mike could not be physically present during those meal times. We decided that Mike would pack a breakfast and lunch for Sam during his evening shift and to leave a written message for the morning staff to give him these meals.

At the fifth session, Sam had regained the two pounds, potentially due to Mike’s initiative to pre-pack meals. The focus of this session was on Sam’s atypical issues with food. Sam stated that he detested most spices (e.g., pepper, garlic) and the texture of particular foods (e.g., chicken, onions) but had a fondness for numerous high fat/caloric foods (e.g., donuts, pop tarts, bacon, chips). To accelerate Sam’s weight gain, the therapist suggested that Mike take advantage of Sam’s preference for high caloric density foods. Mike requested and received clearance from the group home to purchase these kinds of foods during the re-feeding process. At session 6, Sam had been expelled from school for illicit drug use and his weight had dropped approximately one pound. The following week (session 7), Sam’s weight was

up 1.5 pounds. However, Sam reported that he still was not eating breakfast. Furthermore, he was attending a drug/alcohol program from 11:30-3:30 each day and reported that he could not bring food into the center “because it could have drugs in it”. Thus, it became apparent that Sam was still not eating any food until Mike began his shift at 3:30. Interestingly, for the first time, Sam reported feeling hunger during the day and expressed that if food was available, he would eat. Mike concurred that Sam’s appetite was growing. In fact, on the previous day Mike and Sam reported that he consumed three peanut butter and honey sandwiches for afternoon snack, five slices of pizza for dinner and ten tortillas with butter for his evening snack (Sam denied any loss of control during eating episodes). Two of these meals, if accurate, were objectively large, however, given Sam’s starved state and the time frame in which he was eating, it was not viewed as problematic. Instead, we discussed strategies to spread out Sam’s meals throughout the day (e.g., 3 meals and 2-3 snacks) as opposed to 3 large meals in the afternoon. Mike suggested that Sam eat lunch on the bus ride to his program and problem solved about buying food from the vending machine.

At the next session (session 8), Mike stated that due to personal reasons he had reduced his hours at the group home and was concerned that he could not handle the re-feeding alone. The therapist (VA) and clinical supervisor (KB) visited the group home the following week to educate the

staff about the effects of AN, administration of FBT-AN, and to recruit their assistance in the treatment process. In general, the staff was very receptive to our presentation. However, many of the staff members stated that they believed Sam was using his weight/eating as a way to get “special attention”. We discussed how Sam may have been reinforced (e.g., extra attention) through the re-feeding process but that it was extremely unlikely that he would be able to maintain such a low weight for this sole purpose. Lastly, we explained the rationale of FBT-AN and requested the other staff members work with Mike to optimize Sam’s chance of recovery. The team agreed to keep track of Sam’s intake and make certain that he eat an appropriate amount at each meal.

At the following session (session 9), Mike reported that Sam was showing more initiative in eating on his own. Interestingly, Sam reported an increased interest in eating and stated that he was “starting to feel hungry” again. Staff members’ reports of Sam further supported these observations. Mike stated that in their weekly meeting, all staff reports were that Sam was eating independently and on occasion even taking additional servings of food on his own. In addition, Mike reported that Sam had recently had a medication change that seemed to be helping with his mood and appetite. Given this information and Mike’s decreased availability, we decided to move to monthly sessions and begin phase 2 of treatment. The only concern of making this transition was that Sam’s weight still placed him at 80% IBW

(Typically, this transition occurs once the adolescent is around 90% IBW), however given the circumstances it seemed like the most feasible option for all involved. The plan was to have Sam eat his meals independently (with staff supervision) and to have Mike weigh him once a week to ensure that his weight was continuing to move in a positive direction.

Phase 2 (Sessions 10-13)

Session 10 occurred approximately one month later. Sam had gained 4.5 pounds and stated that he was now eating throughout the day (i.e. 3 meals and 3 snacks) and no longer consuming large meals. After praising Sam and Mike for their hard work, the therapist encouraged Mike to create an incentive system for Sam's continued weight gain. In session, Mike and Sam agreed that if Sam gained another 4 pounds by the following session (1 month later) that Mike would take him on a special outing (of his choosing) for the afternoon. At session 11, his weight had increased another 3.5 pounds that Mike deemed "close enough" and agreed to take Sam out for the afternoon. Mike noted the significance of Sam's weight gain given that he had resumed playing sports (e.g., basketball).

At session 12, Sam's weight had decreased by $\frac{1}{2}$ (0.5) pound. Mike was surprised by this but at the same time stated that he had taken family medical leave and had not been at work much over the past two weeks. In addition, Mike remembered that Sam had switched schools once again due

to a weapon-related incident and since starting the new school Sam had not received breakfast (approximately 3 weeks). Mike stated that it often takes weeks for the schools to begin serving food to the new students. The therapist encouraged him to contact the school administrator and explain the urgency for Sam to eat (given his diagnosis). In addition, as a back-up plan, Mike agreed to provide Sam with money to purchase breakfast until his meal plan began.

At our final session (13), Sam had gained another two pounds bringing his weight to 115 pounds (87% IBW). Mike stated that over the past month he had spent little time with Sam as his role at the group home had become more administrative. Sam stated that he had been “eating everything” and that he had no concerns about weight gain. This last session was used as a time to reflect on Sam’s progress and also to discuss relapse prevention. Behaviorally, Sam had made numerous changes. In our first meetings Sam said little to nothing and typically sat alone in his room at the group home (often in the dark). In contrast, over the last few months he was talking much more and typically played sports or “horse played” with his roommates at the group home. We discussed the significance of this in terms of his social transformation but also his ability to be active and still gain weight. In terms of future plans, Sam stated that he would be staying at the group home until he turns 19 years old (approximately 3 years). We discussed Sam’s need to continue weight gain and how living at home would provide an ideal

environment in which his weight can continue to be monitored. The therapist stressed the importance of Sam being able to achieve and maintain a healthy weight before living on his own. Sam stated that he plans to keep eating primarily because he did not want to end up in “a hospital and be tube fed.” The therapist encouraged Mike to continue monitoring Sam’s weight and to regularly discuss his progress at their staff meetings.

6-month Follow-up

Sam and Mike returned to the clinic for a follow-up visit with another therapist because the first author had moved positions. Sam’s height had increased slightly (i.e. $\frac{1}{2}$ inch) and his weight had dropped 3 pounds placing him at 81.5% IBW. Mike reported that initially after discontinuing treatment that Sam’s weight continued to increase up to 120 pounds. However, soon after, Mike reported that several major events had occurred that were likely related to his ultimate weight loss. Most notably, Sam had been moved to another residential facility as a result of bullying another adolescent at the home. During that time (approximately 1.5 months), Sam’s weight dropped from 120 pounds to 113 pounds. Sam reported that at the new placement, he was isolated, missed Mike and had no accountability for his weight. In addition, he stated that he was “really depressed and the food was bad.” Per Mike’s report, Sam had been back at the original group home for approximately the past 3 months and quickly increased his weight to 115

pounds. However, due to school re-entry related issues, Sam did not receive his meals for several weeks and his weight dropped back to 113.

In general, Sam reported that his appetite had remained “good.” He typically eats 3 meals per day and was working to incorporate snacks into his routine. Mike reported that while they were regularly weekly weighing, their scale broke and they had not yet purchased a new one. Furthermore, they had discontinued offering Sam incentives for his weight gain, in part because Mike reported that he did not realize how serious things had become. He agreed to begin a similar system (i.e. 3 pounds per month for a specific reward) and to call the clinic, if needed. When asked about gaining more weight, Sam stated that he would feel “anxious about it” but agreed to work with Mike to come up with tangible rewards that he could receive for doing so.

EVALUATING OUTCOME

Sam’s weight went from 99 pounds (76% IBW) to 115 pounds (87% IBW) in nine months and using the Morgan-Russell Outcome Categories [; >85% of expected weight for height] is considered an intermediate outcome (i.e. partial remission). Over the course of treatment, there were significant social and disordered eating related changes. Sam became more talkative in session and active outside session. He began eating without resistance and endorsed hunger and enjoyment when eating. By our last session, he stated

that he was no longer concerned about weight gain and using DSM-IV criteria, he no longer met criteria for AN. These results are consistent with the results achieved using standard FBT-AN .

In terms of the long-term outcome, Sam's height increased and weight decreased slightly from 115 pounds (87%IBW) at the last treatment session to 112 pounds (81.5% IBW) at the 6-month follow. Using the Morgan-Russell outcome categories, Sam's weight at follow-up is indicative of a poor outcome ($< 85\%$ of expected weight for height). However, taking into account the absence of any eating and body related cognitions, his dramatic change in living arrangements in which his eating was unmonitored, and the DSM-IV criteria for AN, Sam's outcome appears to be encouraging. Indeed, based on Sam and Mike's report, this weight loss was primarily due to external factors as opposed to a return of AN symptoms. Sam self-reported an excellent appetite and stated that his eating "was in a good place." While he did endorse some fear of weight gain, he agreed to try and eat more without any resistance. Studies on FBT-AN that have evaluated follow-up (e.g., 6 and 12 months) have found relatively stable weight from post treatment to follow-up periods . While our findings are less positive than the previous mentioned studies, it is likely attributable to the change in residence as opposed to a return of AN. In addition, this case is remarkable given that it is a non-traditional implementation of FBT with an adolescent presenting without family and numerous psychosocial and behavioral issues.

Moreover, it is difficult to compare our findings to the literature as adolescents with Sam's profile (i.e., atypical eating disorder symptoms, substance abuse) and place of residence would be screened out of these studies.

DISCUSSION

The group setting provided some advantages over the home environment. For example, once on board, there were multiple staff members watching Sam during all hours and ensuring that he was eating properly. When this responsibility falls solely on the parents, it can be both emotionally and physically taxing and can lead to increased marital/family discord. In addition, Sam had numerous peers (male teenagers close to his age) to model his eating after. This is in contrast to a traditional home setting where there typically would be one or two siblings of different ages/or no siblings.

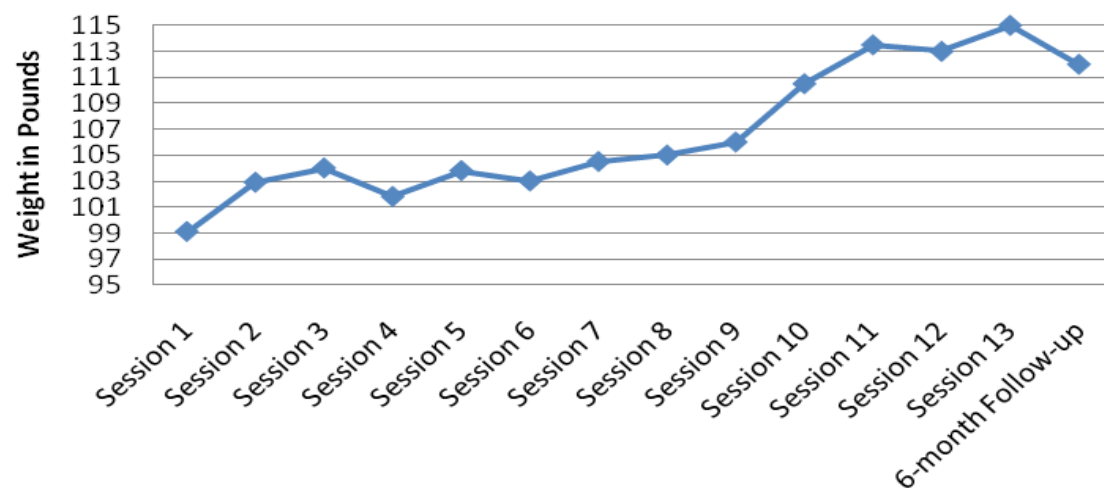
There are also some clear disadvantages. Most notably, there is turnover in providers (in this case, Sarah left) and there can be inconsistencies in caretakers. Additionally, caretakers may have less motivation to continue in the re-feeding process than biological parents. In addition, due to the logistics of a group home—namely the other adolescents that needed attention and care, Sam was expected to eat independently on many occasions even during the early stages of treatment. In FBT, typically

parents are encouraged to focus on helping the child with the eating disorder. Logistically, this can be difficult in the group home setting. Lastly, in terms of follow-up, Sam was removed from the group home due to behavioral issues and placed in another facility in which his eating behaviors were completely unaddressed. It appears that this change was directly related to the majority of his weight loss. The removal of a child from a family setting, in contrast, would be extremely unlikely unless it was into hospital for more intensive treatment.

Overall, we believe that treating Sam with FBT-AN was more successful than other therapies could have been. Providing FBT-AN in a group setting in which multiple staff members are involved in some ways resembles an inpatient unit of a hospital. The primary difference being that in the hospital setting—the primary goal of the staff is a focus on eating disordered behaviors. The adaptations to the traditional model required the therapist to problem solve more logistical related issues (e.g., school policy, meal consumption when the caregiver was not working). In sum, this case supports the application of FBT-AN in non-traditional settings as long as the caregiver(s) are invested in the adolescent's recovery and can monitor his/her recovery in both the short- and long-term. The weight loss that occurred during the follow-up period underscores the importance of continued monitoring, consistency and care—particularly in a setting in which staff are overburdened with daily demands and responsibilities

separate from the patient. Thus, it is recommended that when adapting this model to similar settings, that follow-up visits/phone calls be conducted to ensure proper monitoring of the adolescents' eating and weight. Future opportunities for this adaptation might include FBT-AN for other supported group settings.

Figure 1: Sam's Weight Trajectory



References

1. Keel PK, Dorer DJ, Eddy KT, Franko D, Charatan DL, Herzog DB. Predictors of mortality in eating disorders. *Arch Gen Psychiatry* 2003;60:179-183.
2. Agras WS, Brandt HA, Bulik CM, Dolan-Sewell R, Fairburn CG, Halmi KA, et al. Report of the National Institutes of Health workshop on overcoming barriers to treatment research in anorexia nervosa. *Int J Eat Disord* 2004;35:509-521.
3. Bulik CM, Berkman ND, Brownley KA, Sedway JA, Lohr KN. Anorexia nervosa treatment: a systematic review of randomized controlled trials. *Int J Eat Disord* 2007;40:310-320.
4. Lock J, Le Grange D., Agras & Dare, C., Treatment manual for anorexia nervosa: A family-based approach. New York: Guilford Publications, Inc.; 2001.
5. Eisler I, Dare C, Hodes M, Russell G, Dodge E, Le Grange D. Family therapy for adolescent anorexia nervosa: the results of a controlled comparison of two family interventions. *J Child Psychol Psychiatry* 2000;41:727-736.
6. Le Grange D, Eisler, I., Dare, C., & Russell, G. Evaluation of family treatments in adolescent anorexia nervosa: A pilot study. *International Journal of Eating Disorders* 1992;12:347-357.
7. Lock J, Agras WS, Bryson S, Kraemer HC. A comparison of short- and long-term family therapy for adolescent anorexia nervosa. *J Am Acad Child Adolesc Psychiatry* 2005;44:632-639.
8. Lock J. Treatment of Adolescent Eating Disorders: Progress and Challenges. *Minerva Psichiatr* 2010;51:207-216.
9. Robin AL, Siegel PT, Moyer AW, Gilroy M, Dennis AB, Sikand A. A controlled comparison of family versus individual therapy for adolescents with anorexia nervosa. *J Am Acad Child Adolesc Psychiatry* 1999;38:1482-1489.
10. Russell GF, Szmulker GI, Dare C, Eisler I. An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Arch Gen Psychiatry* 1987;44:1047-1056.
11. National Institute for Clinical Excellence NICE, Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa, and binge eating disorder. In N. C. G. n. 9, *eatord.*, London, NICE, 2004.
12. Lock J, Le Grange D, Agras WS, Moyer A, Bryson SW, Jo B. Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Arch Gen Psychiatry* 2010;67:1025-1032.

13. Association AP, Diagnostic and statistical manual of mental disorders fourth edition. v. 4: Washington D.C.: American Psychiatric Publishing; 2000.
14. Morgan HG, Russell GF. Value of family background and clinical features as predictors of long-term outcome in anorexia nervosa: four-year follow-up study of 41 patients. *Psychol Med* 1975;5:355-371.
15. Eisler I, Dare C, Russell GFM, Szmulker G, leGrange D, Dodge E. Family and individual therapy in anorexia nervosa - A 5-year follow-up. *Archives of General Psychiatry* 1997;54:1025-1030.
16. Eisler I, Simic, M., Russell, G., Dare, C. A randomized controlled treatment trial of two forms of family therapy in adolescent anorexia nervosa: Five-year follow-up. *Journal of Child Psychological Psychiatry* 2005;48:552-560.