Anorexia Strategy: Family as Doctor

When a teenage girl develops anorexia, a team of experts usually takes charge of bringing her back to a normal weight, while her parents stand on the sidelines.

But a promising and controversial new therapy gives parents the primary responsibility for an anorexic child's recovery.

The goal of the therapy is to mobilize the family as a whole in a fight against the eating disorder, said Dr. James Lock, an associate professor of psychiatry at Stanford School of Medicine and the lead author of an extensive treatment manual for the technique, published last year by Guilford Press.

The parents are told that no one knows what causes anorexia — a problem that affects boys but is far more common in girls — and that the illness is no one's fault.

They are encouraged to think of the disorder as an outside force that has taken over their daughter's life.

And they are exhorted to be unwavering in finding ways to feed their child.

The message, Dr. Lock said, "is that food is medicine and medicine must be delivered."

"If not," he said, "this child is at severe risk."

The technique, developed at the Maudsley Hospital in London, is now being tested in the United States.

Preliminary studies suggest it is strikingly effective in helping many adolescents to recover from anorexia, an illness that carries the highest mortality rate of any psychiatric condition and is notoriously difficult to treat.

But it is not without critics.

Traditional theory holds that the self-starvation of anorexia represents an adolescent's desperate attempt to assert independence in the face of overbearing or intrusive parents. Some therapists worry that the Maudsley approach will exacerbate a teenager's feelings of helplessness — and make the illness worse.

Other experts argue that the method may be impractical in many families where two parents work.

Dr. Lock and other experts who use the therapy agree that the therapy is not suited to every family, and that it is impossible to use in a minority of families, those with parents who are abusive or have other major psychiatric problems.

But the experts say that in many cases, the parents are in the best position to help an adolescent get better, especially in a world of managed care, where hospital stays are short and therapy sessions are limited. Helping an adolescent in trouble is "normally what we would expect a family to do," Dr. Lock said.

But, he added, parents "often get thrown off by being told they are at fault, that they can't do anything about it or that they need someone else to do it."

The principles underlying the approach, he said, are similar to those used in residential eating disorder programs.

In those programs, Dr. Lock said, "One of the first things you notice is that the children, when you take the responsibility for food and eating away from them, can actually eat. They're not torn and conflicted and they usually can gain weight."

And once a safe weight is restored, he and other experts contend, the child can move, unencumbered, to the other developmental tasks of normal adolescence — the focus in the second part of the therapy, when responsibility for eating is gradually shifted back to the child.

Dr. Katharine L. Loeb, a research scientist at the New York State Psychiatric Institute in Manhattan who is directing a pilot study of the therapy, said many parents expressed perplexity about ways to induce a resistant teenager to eat.

"I tell them: `The same way you got her to take a distasteful medicine when she was younger. It wasn't a matter of taking the antibiotic or not, but of how it was going to happen,' " she said.

Dr. Loeb said the parents might say to their daughter, "Don't think that it's an option not to eat because we are not going to let you starve."

In some cases, they may tell an adolescent she cannot leave the table until she has eaten a certain amount. Or they may emphasize the rewards that come with weight gain — and the gains in health and physical strength that accompany it.

For example, Elizabeth H., a 15-year old from Westchester County who participated in the study, said it was the promise of a bicycle trip to Cape Cod — a trip she would be physically capable of only at a higher weight — that made the difference.

"All I could think of was a tunnel vision of my trip," she said. "So I gained 20 pounds in two months."

Whatever approach the parents adopt, they must be "at the same place on the same page" in their efforts, Dr. Loeb and other experts said. The therapist monitors the process, offering suggestions and making sure parents do not use the treatment as an excuse to indulge in emotional tyranny.

"This is not a green light for parents to be aggressive, controlling or hostile" toward their children, said Dr. Daniel le Grange, director of the eating disorders program at the University of Chicago and an author of the treatment manual.

The evidence that the Maudsley approach works is increasing, but still limited. An early study by Dr. Gerald Russell and his colleagues at the Maudsley Hospital reported the method to be more helpful than individual therapy for adolescents who had been ill for three years or less. Later studies by Dr. le Grange and other researchers also found the therapy successful in preventing hospitalization and helping adolescents recover their normal weights. And Dr. le Grange said that in a follow-up study, as yet unpublished, at least 75 percent of patients maintained their recovery at five years.

Dr. Lock is now conducting the largest controlled study of the therapy — indeed, of any treatment for adolescents with anorexia — comparing 6 months and 12 months of treatment in about 86 patients, about 9 percent of them boys.

Still, making parents the prime agents of therapy is at odds with more traditional views of anorexia. Many researchers now believe that a predisposition to the illness, which tends to run in families, may be genetic.

But older theories in part blamed parents for the development of the eating disorder and regarded self-starvation as part of a larger battle over control and independence.

And even today, many therapists distrust parents' becoming too involved in their child's treatment, echoing a view expressed more than a century ago by Sir William Gull, the English physician who coined the term anorexia nervosa. "Relations and friends," Sir William wrote, were "generally the worst attendants" for anorexic patients.

Other experts do not dispute the value of parental involvement, but they question how broadly the Maudsley approach can be applied, a question they say will be answered only by more studies.

Dr. David Herzog, a professor of psychiatry at Harvard Medical School, noted that every treatment for anorexia must balance the child's need for autonomy with the medical necessity of getting her to eat.

But different families may require different types of treatment, he said. And while some teenagers may be responsive to parents' taking charge, "there are others who need to be separated from their families, at least for some period of time," he said.

Anorexia is a lethal illness. In a long-term follow-up of women with anorexia, Dr. Katherine Halmi, director of the eating disorders program at the Westchester division of New York Presbyterian Hospital, and her colleagues found that 7 percent of them had died after 10 years. In a Swedish study that followed patients for 30 years, 18 to 20 percent of the women died.

Even when anorexia does not kill, patients often suffer long-lasting medical complications. Bones become fragile. Heart muscle is damaged. Hair thins. Skin bruises easily.

In adolescents, Dr. Loeb noted, anorexia can develop so insidiously that parents sometimes do not realize that something is wrong until their child becomes drastically underweight.

Making detection more difficult, many normal teenage girls diet or indulge in odd eating habits. And adolescence is a time of changing bodies, rapid spurts of growth — and baggy clothing.

"All the kids were shooting up and getting thinner," said Elizabeth H.'s mother. "If you looked at her in clothes, you really couldn't tell."

Teenagers with anorexia, many experts said, often become young tyrants, demanding that parents provide minuscule portions or buy only fat-free foods, taking hours to finish a meal or lying about how much they have eaten during the day.

But bargaining, Dr. Lock said, only plays into the illness.

"With anorexia, you never win, you always lose," he said. "If you start with broccoli, soon it's going to be half a serving of broccoli."

For parents, participating in the therapy often means rearranging their work schedules or taking leaves of absence so that they can be present to supervise every meal. In one family, said Dr. le Grange, the parents would sit with their daughter at breakfast, and then send an e-mail message to her school counselor, listing what was in her lunchbox. The counselor then supervised her lunchtime meal.

Early in the therapy, he and other experts said, the therapist underscores the dangerous nature of the illness and tries to instill in the parents a sense of urgency. Siblings, too, are urged to do their part. One small boy, recalled Dr. le Grange, decided his job would be to give his older sister a hug once a day.

The family is also directed to bring in a picnic meal representing the kinds of foods they think are appropriate to restoring their child's weight.

Some families in the pilot study, Dr. Loeb said, bring fettuccine alfredo, a dish good for starved bodies that need calorie-dense food in order to gain weight. Others arrive with carrot sticks and fat-free yogurt, believing it is what their daughters will agree to eat.

"It's not because they don't care," she said, "but because there was a big battle and they let the child be involved in picking the food."

Over the course of treatment, Dr. Loeb added, parents begin to realize that with a combination of determination and creativity, they can get their child to eat.

But at least initially, the child herself may not be so enthusiastic.

A 16-year-old girl participating in the pilot study, for example, said she disliked the whole approach.

"I have a great deal of concern that right now I'm trying to separate from my parents and become my own person," she said, "and I'm scared that the goal of the treatment is to give the parents total control."

Her mother, on the other hand, said she felt the Maudsley therapy "put the power back in the family."

"It gives me a parental mandate," she said. "I'm there, and I'm going to be more dedicated to getting rid of this problem than anyone because it's my child."

For now, the whole family — mother, father and daughter — has agreed to give the Maudsley therapy a chance.

The process, Dr. Loeb said, is likely to test their strengths as a family and challenge their patience.

"But parents do it anyway," she said, "because they need to save their daughter's life."

Please answer all questions in complete sentences. **Name: _____ Hour_____**

a. According to Dr. Lock, what is the goal of the Maudsley approach to treating anorexia?

b. Why is the Maudsley approach considered controversial?

c. How do traditional theorists usually perceive the role of the parent in treating eating disorders among adolescents?

d. According to Dr. Lock, what happens when you take "the responsibility for food and eating" away from anorexia patients?

e. What approaches have anorexia patients' parents adopted in order to induce their children to eat?

f. How have research studies on the Maudsley approach to treating anorexia shed light on its effectiveness and on its limitations?

g. What medical complications may arise among anorexic patients?

h. Why have few systematic studies been done on anorexia?

Why is detecting anorexia among adolescents sometimes difficult?

j. What does Dr. Lock mean by the quote, "With anorexia, you never win, you always lose"?

k. Why did one mother equate the Maudsley approach with receiving "a parental mandate"?