The power of the family in general practice:

Enhance your effectiveness when caring for anorexia nervosa patients

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There is a tendency for all living things to join up,
establish linkages, live inside each other,
return to earlier arrangements, get along whenever possible.
This is the way of the world.

– Lewis Thomas, The Lives of the Cell (1974)

ABSTRACT

Anorexia nervosa (AN) is a severe condition and is influenced by a variety of factors, most notably social environment. Family therapy has been shown to be effective in the treatment of AN, particularly in patients under the age of 19 years. However, while general practitioners (GPs) are often the first point of contact for patients, family therapy is not often introduced during the initial assessment. The aim of this paper is to introduce the key concepts of family therapy to aid GPs during the assessment and treatment planning, so that the benefits of family therapy can be made fully available to patients with AN.

Key words

Eating disorder, family process

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General practitioners are strategically placed on the frontline of care delivery and have significant experience and skill in working with families across multiple generations. This paper is designed to add to the generalist perspective the 'power of the family' and offer techniques for detection, support and stabilisation of anorexia nervosa, a complex eating disorder. A partnership between physician, patient, and family may provide the most effective and efficient form of medical care in general.[1] This partnership is especially important in the treatment of anorexia nervosa.

Anorexia nervosa (AN) is considered by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to be a severe, distressing and often chronic mental illness.[2] AN is characterised by intense anxiety, preoccupations with body weight and/or shape and extreme control over eating and weight and has a mean duration that can range from five years to a lifetime for some patients.[2] Of concern for the general practitioner (GP) is the high death rate and strong denial that is very common among anorectic girls. Indeed, a recent review

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indicated that anorectic girls have the highest mortality per capita of any psychiatric disease (up to 6% per decade of illness).[3]

The importance of the involvement of family members in the assessment and treatment of AN is recognised by the RANZCP in the *Treatment guide for consumers and carers,*[4] as well as the United Kingdom's National Institute for Clinical Excellence.[5] Furthermore, in the Practice Guidelines for the *Treatment of patients with eating disorders* published by the American Psychiatric Association, problems with family relationships are indicated as potential contributing factors to the maintenance of the disorder.[6] However, the RANZCP suggests that there is no research proving a link between family dysfunction and the onset of AN. Nonetheless, there is strong evidence to support the use of family therapy as a treatment modality in patients under the age of 19 years.[7]

Family systems concepts

These concepts are the foundation and language that are used when working with families. Family characteristics and family structure, including hierarchy, boundaries, family role selection, alliances, and coalitions, are concepts that are observed on a daily basis on the frontline. Heightened awareness of the family processes including enmeshment, disengagement, triangulation, and family patterns provide power as these processes are challenged.

Clinical case review

A 16-year-old girl who had lost 9kg over three months was referred by her GP. She had a body mass index (BMI) of 17. She was restricting food, compulsively exercising and had amenorrhea. Medical investigations were unremarkable. A family assessment was conducted with mother, father and two younger siblings; father worked professionally and mother was at home. The adolescent was leaving for university and the 'launching of children', a stage of the family life cycle, was reviewed. Boundaries, subgroups, and hierarchies were observed along with shifting alliances and coalitions. The family, together with the therapeutic team including the GP, worked to ameliorate her AN through support and restructuring her context to ensure a successful launch was effective. At discharge, her BMI was 20. The continued care was provided by her GP and University Health Centre. (The Family Therapy Model is based on general systems theory and focuses on contemporary forces influencing and maintaining the symptoms.)

Prevalence

The Christchurch Psychiatric Epidemiology Study (CPES) found only three women per thousand in the general population suffer from AN.[9] From our clinical and research experience, this finding is consistent with both the general New Zealand population and the worldwide patterns of prevalence. With such a low rate, the CPES study found it difficult to address risk factors for the development of AN. As sometimes happens in general practice, the attention and resources that are required are vastly out of proportion to the prevalence. However, the severity of AN is compounded by associated medical problems including osteoporosis, amenorrhoea, hypoglycaemia, and multi-organ failure.[10]

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Risk factors

Identifying risk factors has proved to be an illusive exercise for many reasons including the failure of previous studies to use appropriate methodology and the fact that although disordered eating can be demonstrated, only a small proportion of women develop a full anorexic syndrome. However, being female and being young are two of the most clearly identified risk factors.[11] Additionally, being Westernised and upper-middle class has been asserted to be a risk factor. Richard Gordon interviewed South Korean psychiatrist Kim Joon Ki; prior to 1991, Kim had seen only one patient with an eating disorder (ED) however by 1997, he had seen over 200. As Gordon points out, these changes were concurrent with *'the forces of industrialisation, consumerism and democratisation'* that produced a *'rapid cultural transition'*.[12] Even in economically deprived countries like India, EDs are starting to manifest. This phenomenon is again co-occurring with the rapid commercial and industrial development and the emergence of high technology.

Anne Becker, a psychiatrist and anthropologist, visited Fiji on two occasions separated by eight years. On her first visit in the early 1990s, the overweight Fijian women were accepting of their size. Upon her return, there

Early clues and behaviours of anorexia nervosa[4]

- **Family history** of anorexia.
- **Occupational groups** e.g. ballet dancers, gymnasts, jockeys and models.
- **Physical clues:** loss of periods or failure to begin menstruating, weight loss without evidence of any other illness.
- **Psychological clues:** obsessive concern about body weight, shape and dieting, unrealistic perception about being fat, extreme fear of getting fat or gaining weight or of eating.
- **Behavioural clues:** cutting out foods once enjoyed, excessive exercise, vomiting and using laxatives, and avoiding sharing meal times with others.
- **Body weight** of 15% lower than expected, or BMI < 17.5.

were large numbers of women, especially teenagers, who were unhappy with their body size and were actively dieting. Again, the change to Fijian culture was attributed to the introduction of the television.[12]

A key aspect of Western culture that is regarded to be an ED risk factor is the cultural value that thinness is beautiful. Media exposure has been difficult to study – measuring exposure is quite approximate. However, there is a perception that women (including young girls) are bombarded by TV, magazines, and movies carrying the ubiquitous message that the ideal body image is 'thin'. In spite of this avalanche of body image pressure on women, the disease remains rare.

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Evidence-based treatments

Christopher Fairburn recently questioned whether evidence-based treatment of AN was possible.[13] Fairburn indicated that there was a range of treatment options and treatment settings, within which are a variety of interventions: pharmacological, psychological or both (often more than one treatment is employed within any one setting). There is limited research on the treatment of AN and much of it is inconclusive. The reasons for this lack of research are many but the major one is that AN is uncommon. Nevertheless, we have included some common treatment outcomes.

Medications

A search of randomised-control trials (RCT) for medication research found studies that were limited by small sample sizes and research design. Most studies add medication to comprehensive hospital-based treatment programmes making it difficult to determine unique effectiveness. Several classes of pharmacologic agents have been studied in patients with acute AN without finding clear benefits to eating, weight, body shape concerns and associated psychopathology.[14]

Traditional antipsychotic medications are not considered in routine care due to their significant side effects and limited evidence of their clinical benefit. However, atypical antipsychotic medications may have a role in the treatment; an RCT is the necessary next step.[14]

Fluoxetine may be helpful in preventing relapse in weight-restored AN patients.[15] However, fluoxetine offered no benefit when compared with placebo to AN inpatients undergoing weight restoration.[14]

It is unclear why the medication trials conducted to date have been so universally discouraging. There is criticism that the studies consistently appear to be driven by only two general hypotheses – appetite stimulation and alleviation of symptoms such as anxiety and depression.[14]

Psychological therapies

Of the few RCT for AN, most have focused on adolescent patients and suggest that family therapy is an effective treatment for these patients.[16] The benefits of family therapy with adult patients, however, have been less clear. In addition, attempts to demonstrate effectiveness of Cognitive Behavioural Therapy (CBT) in AN have yielded only equivocal results.[17]

Psychosomatic Family Model

In the early 1970s, three girls in their early teens with severe uncontrollable juvenile onset diabetes (Type I) were admitted to the Children's Hospital of Philadelphia in diabetic ketoacidosis. Salvador Minuchin and his group from the Philadelphia Child Guidance Clinic were investigating psychosomatic illness and made a startling observation: the girls' diabetes spiralled out of control in only one context – the home. The Minuchin team hypothesised that some family interactional pattern may be contributing to these exacerbations. They tested a model they called the Psychosomatic Family. This family is characterised by: rigidity, triangulation, diffusion of conflict, and over protectiveness. They proposed that it was dysfunctional patterns observable in the therapy room that contributed to the patient's illness or symptoms.

To determine how these family patterns affected diabetes, Minuchin studied the physiologic responses of diabetic children to a stressful family interview.[18] Summarising the pioneer work of the Family Stress Interview, the researchers measured the free fatty acids of the family members to determine where and when the acids arose relative to the interactional patterns within the family. If one assumes that free fatty acids correlate with stress, the interviews demonstrated the relationship between symptomatology and the family interactional patterns. Parents' free fatty acids drop as their conflict is detoured or diffused through the chronically ill child. The child's free fatty acids rise steeply – a huge cost to the child in terms of exacerbation of symptoms. And to the extent the parent's focus moves from their conflict to their child, their stress has been decreased, thus stabilising the family system.

Following on from their work with uncontrolled diabetes, the Psychosomatic Family Model provided the framework for anorexia patients. In the original psychosomatic project, follow-ups were conducted with 53 anorectic adolescents (mean age of 14) over two to seven years.

GP role in initial assessment[4]

- Full physical check up
- Provide diagnosis
- Organise other health professionals – including a referral to a psychiatrist

The findings indicated that 86% were asymptomatic with good psychosocial functioning. A study by Martin[19] conducted with anorectic adolescents in Toronto and followed-up at five years used a similar treatment approach and found the same degree of success in outcome.

The Maudsley Family-based Treatment Model

In the mid 1980s Christopher Dare and colleagues at the Maudsley Hospital of London developed a model with a focus on many of the tenets and assumptions as the Minuchin Model.[20] Parents work together and form a crucial role in the treatment of their anorexic child. The results favoured family-based treatment (FBT) known as the 'Maudsley method'.[16]

Benefits of family interventions

(literature review by McDaniel et al.[1])

- Minuchin successfully treated psychosomatic families using Structural Family Therapy to disengage the diabetic children and establish more appropriate boundaries. In 15 cases, the pattern of recurring ketoacidosis ceased and insulin doses were reduced.
- Two RCTs of family therapy in severe childhood asthma reported improved health outcomes. The children who received family therapy had reduced symptoms, medication use, and school absences. Their lung function improved as well.
- One of the most successfully documented family interventions is family psychoeducation. This intervention provides information, support, and problem-solving skills to help families cope with a chronic illness. It has been shown to improve the outcomes in childhood diabetes, asthma, recurrent abdominal pain and developmental disabilities.
- Two types of family interventions are effective in the treatment of hypertension. Couples-communication training, in which one of the couple has hypertension. In one large study, providing family support to assist with compliance with blood pressure medication resulted in improved compliance, reduced blood pressure and a 50% reduction in mortality.
- For more on the benefits of family interventions and the complete literature review, see McDaniel et al.[1]

Practical strategies for the general practitioner

Many of the tenets of the Psychosomatic Family Model serve to instruct the GP to assess and intervene with families of AN patients. The important contributions of researchers who work at the interface between medicine and family interventions can provide, in our opinion, practical strategies for the GP. Their work, based on grounded observations of family interactions, extrapolates to the general practice frontline in the following ways:

- The family partnership to diagnosis and treatment should be engaged early. Family patterns are very likely to be observed in your consultation room if members of the social context are included. The family serves as the doctor's eyes and ears and provides support and safety nets for the anorexia sufferer.

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- Beware of triangulation. When conflict starts to arise, a third person is recruited into a two-person system in order to diffuse the conflict and the stress in the system. The GP is most often in the best position to determine contextual trouble-signs such as triangulation. When a child becomes symptomatic, look for triangulation. It tends to be a consistent characteristic of the Psychosomatic Family that is seen not only with AN but also with other psychosomatic problems.
- Conflict avoidance. The family should be encouraged to support the sufferer to address, and not avoid, the conflicts in their life, to be proactive and assertive in their relationships.

Key Points

- Encourage family partnership
- Beware triangulation
- Beware conflict avoidance

WARNING

The Food and Drug Administration (FDA) in 2004 concluded that children and adolescents taking antidepressants had elevated risks for suicidal thoughts or attempts.[8]

Conclusion

Family Therapy is a discrete skill set that requires considerable training and is effective in the treatment of AN. As indicated by the RANZCP, the GP is often the first point of contact and although he or she is not expected to conduct family therapy, the points noted above aim to help enhance understanding and improve assessment and treatment. In addition, the GP may organise other health professionals to be involved in the treatment plan,[4] as treatment of AN is best served by multidisciplinary teams who can address the medical and psychiatric complexities of this disease. Nonetheless, the GP remains central to the medical care and is the key clinician for oversight prior to and after psychological interventions. The family is the true partner and empowers the team.

Competing interests

None declared

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