

Evidence Based Practice for Eating Disorders

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Progress Through Science

“Truth never triumphs, its opponents just die out. Science progresses one funeral at a time” - Max Planck- inventor of Quantum theory and winner of Nobel Prize in Physics, 1918

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Problems for Progress

- Career
- Ego
- Money
- Power
- For instance-
 - Medication and Psychoanalysis, Ulcers, Hand Washing
 - Climate Change

Science

- Philosophical naturalists often appeal to the metaphor of “Neurath’s Boat,” named after the philosopher who developed it. Our situation as inquirers trying to understand the world around us, according to Neurath, is like that of sailors who must rebuild their ship while at sea. These sailors do not have the option of abandoning the ship and rebuilding a new one from scratch. They must, instead, try to rebuild it piecemeal, all the time staying afloat on other parts of the ship on which they continue to depend.

Science

- In this sense, we are also “at sea”: we cannot abandon all the knowledge about the world we have acquired from the sciences and then ask what we really know or what is really rational. The sciences that have worked so well for us are precisely our benchmark for what we know and what is rational; they’re the things that are keeping us “afloat.” Extending this metaphor, when you hear someone say, “I know the ideal form a ship should take – it is intuitively obvious, I am confident in it – so let us jump into the ocean and start building it from scratch,” then run, because you are going to drown. (from Brian Leiter and Michael Weisberg, *The Nation*, October 22, 2012)

Theory

- A good writer can, of course, make anything sound convincing, and that’s particularly true when they’re spinning a tale you already want to believe. But those tales, when they’re contradicted by the bulk of the data, are typically wrong, and should be treated with immense suspicion. (Author unknown to me, will look for reference)

Evidence Based Care

- Standard of care
- Scientific studies have been done
- Studies show superiority for this treatment
- Not anecdotal
- Not about clinical experience- helpful, not science
- Must be measured
- Not about theory

What is Evidence Based Practice

- ◆ Defining EBP
- ◆ What does EBP look like with ED

APA Policy Statement, 2005

- ◆ *Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.*
- ◆ Adapted from IOM, 2001 and Sacket, 2000

Evidence Based Practice

- ◆ The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention.



Lets break that down....

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How Do We get Evidence?

- ◆ Randomized Clinical trials
- ◆ Allocation Ratio- equal probability to get each treatment
- ◆ Many methodologies- all have been tested over time

Statistical Power

- ◆ Significance- Probability that results come from chance alone
- ◆ Effect Size- Size of difference between treatments
- ◆ Sample Size- Larger the sample, the greater the power of the evidence

Other factors

- ◆ Patient Recruitment
- ◆ Patient Retention
- ◆ Missing Data
- ◆ Correlations vs Causation

How are Studies Done

- ◆ Hypothesis
- ◆ Define Variables to Study
- ◆ Prioritize Variables
- ◆ Define Instruments to Measure Outcome
- ◆ Train researchers in clinical quality and excellence of data analysis

Research in Children and Adolescents

- ◆ Easier Recruitment
- ◆ Less dropout
- ◆ Good research on FBT
- ◆ Lack of individual therapy research
- ◆ Lack of pharmacology research
- ◆ Medical Safety only sometime included

Overall Issues with Research

- ◆ Generalizabilty
- ◆ Therapist training
- ◆ Modifications from research to clinical practice

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Clinical Expertise

- Let's look at Anorexia Nervosa

Anorexia Nervosa

- ◆ **Refusal to maintain min. body weight**
- ◆ Intense fear of gaining weight or becoming fat, even though underweight
- ◆ Disturbance in experience of weight or shape, undue importance of weight or shape, or denial of seriousness of problem
- ◆ Amenorrhea (in females)

What does CLINICAL EXPERTISE tell us about how to evaluate “refusal to maintain body weight at or above a minimally normal weight for age and height (i.e., ..less than 85% of expected” in adolescents....

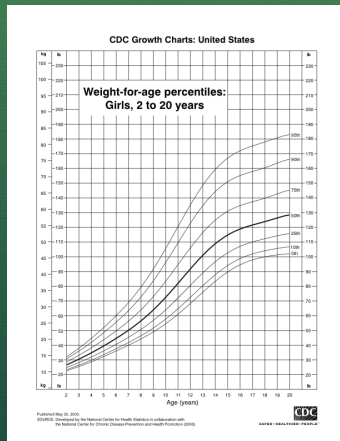
Percent Ideal Body Weight

1. Current weight/ideal weight \times 100 less than 85%
 - a) 50th percentile weight for height, age, and gender = proxy for ideal
 - b) NCHS norms 1973
2. % IBW less than 85% using weight corresponding to the 50% percentile BMI for age
 - a) NCHS norms 2000

BMI Standards used in Research

- ◆ BMI equal to or below 18.5
- ◆ BMI-for-age percentile equal to or below 5%
- ◆ Significant change in BMI-for-age

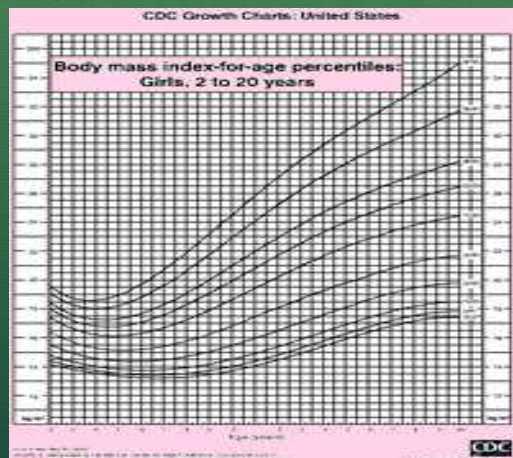
Growth Charts- Clinicians Expertise



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Growth Charts



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Healthy Weight vs Healthy State

- ◆ Clinical experience says that we can try to predict goal weight, but we may be wrong
- ◆ Getting to a number doesn't mean the work is done
- ◆ Individual characteristics matter a lot
- ◆ Focus on obesity in pediatrics may distort understanding of healthy state

Clinical Expertise

- ◆ Researchers don't use growth charts
 - Hard to obtain
 - Hard to standardize
 - Not designed for research
- But, clinically they may still be most useful in reaching a healthy state

Clinical Expertise

- Doesn't mean experience matters more than research
- Doesn't mean you can have your own boat

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Treatment of Adult EDs

- ◆ Cognitive Behavioral Therapy (CBT)
- ◆ Interpersonal Psychotherapy (IPT)
- ◆ Family Therapy (Maudsley)
- ◆ Dialectical Behavior Therapy (DBT)

Treatment of Adolescents with ED

◆ Family Based Therapy (FBT)

- Maudsley Approach

◆ Cognitive Behavioral Therapy

- DBT
- IPT

Culture and Context

- Family is the prime cultural component
- Family is where the treatment happens
- Choosing therapy needs to be based on culture, context and patient characteristics

Family Based Therapy

◆ Treatment Philosophy

- Family doesn't cause the ED
- Family is not dysfunctional
- Family in control of patient's eating
- Family learns how to set loving limits

Three Phases of Treatment

- ◆ Phase I (sessions 1-10)
 - Goal: parents restore child's weight
 - Session frequency: weekly
- ◆ Phase II (sessions 11-16)
 - Goal: transfer control back to adolescent
 - Session frequency: bi-weekly
- ◆ Phase III (sessions 17-20)
 - Goal: work on adolescent development issues & termination
 - Session frequency: every 3 weeks

Appropriate Candidates for FBT

- ◆ Age < 18 years
- ◆ Diagnosis of Anorexia Nervosa
- ◆ Eating Disorder history < 3 yrs
- ◆ Newer Work on BN, BED

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Data for FBT

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Anorexia Nervosa Studies

Uncontrolled

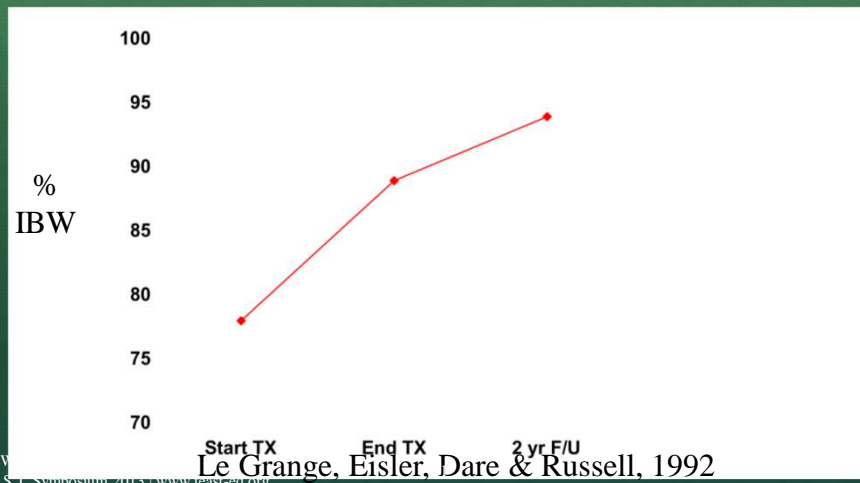
- ◆ Minuchin et al (1978)
- ◆ Dare (1983)
- ◆ Martine (1984)
- ◆ Stierlin & Weber (1987; 1989)
- ◆ Meyer (1994)
- ◆ Herscovici & Bay (1996)
- ◆ Le Grange & Gelman (1998)
- ◆ Lock & Le Grange (2001)
- ◆ Wallin & Kronwall (2002)
- ◆ Le Grange et al (2005)

Controlled

- ◆ Russel et al (1987)
- Eisler et al (1997)
- ◆ Le Grange et al (1992)
- Eisler et al (2002)
- ◆ Robin et al (1994)
- Robin et al (1999)
- ◆ Geist et al (2000)
- ◆ Lock et al (2010)

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Second Maudsley Study: End of TX and F/U

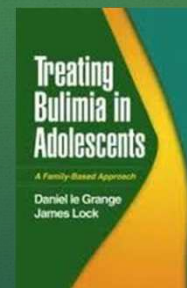
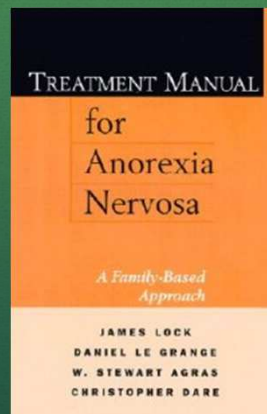
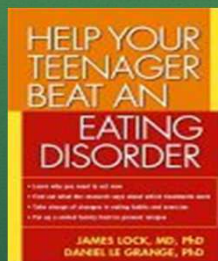


Conclusions per Le Grange & Loeb, 2005

- ◆ Maudsley approach used with young AN patients with short duration of illness is promising.
- ◆ The beneficial effects of the treatment appear to be sustained in 2-5 year follow ups.

FBT vs. IT for Adolescents with AN Lock et al, 2010; Arch Gen Psych

- ◆ Full remission at end of tx: 42% v 23% (ns)
- ◆ Full remission at 6 and 12 months: FBT > IT
- ◆ Relapse at one year: 10% v 40%



60% is not 100%

- Go back to science
- Don't go to theory without proof
- Look in other areas of ED and MH that have good results
- Don't jump off the boat

Staying Afloat in Treatment

- Always use FBT as first line treatment
- Everything discussed after this point is about augmenting benefits of FBT, not replacing
- We are trying to find ways to improve outcomes
- These augmentations are not intended to replace FBT
- Clinical expertise suggests they are possible additions to FBT in some circumstances, not substitutions
- We are doing research, our data is not complete

What Doesn't Work

- Waiting
- Individual therapy for weight gain or behavior change
- Love without Food
- Understanding
- Explanations
- Statements about looking big or small
- Comparisons

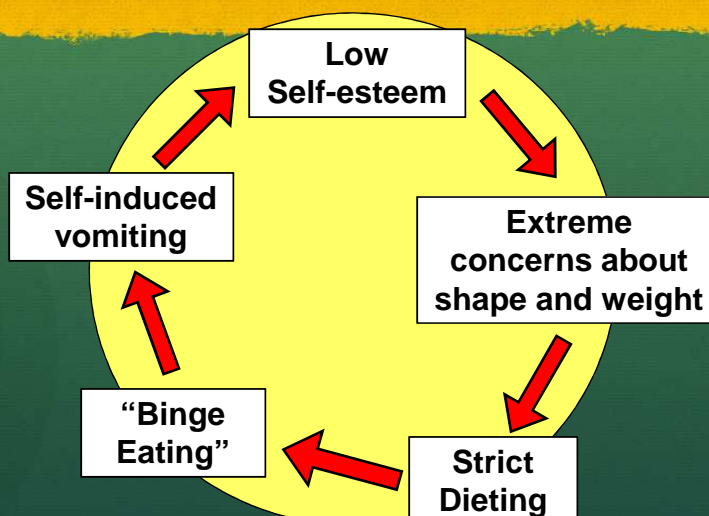
Treatment of Eating Disorders

- Cognitive Behavioral Therapy (CBT)
- Interpersonal Psychotherapy (IPT)
- Family Therapy
- Dialectical Behavior Therapy (DBT)

Cognitive-Behavioral Treatment

- Shown in Adults to be superior to:
 - wait list control
 - antidepressant drug treatment
 - supportive psychotherapy
 - focal psychotherapy
 - pure behavior therapy
 - exposure with response prevention

Model of CBT



Cognitive-Behavioral Treatment

- Clearly the treatment of choice for Adults
 - but not necessary or sufficient for all patients
 - Tends to work best with unwanted issues like purging or depression

Data for AN much less promising, to date- although much work is going on

CBT assumes that thoughts are primary and by changing them we move towards recovery- but doesn't work as well with AN

Why DBT for EDs?

- ED patients have impaired emotion regulation
- ED behaviors are self-harming
- Emphasizes validation and acceptance
- Treatment for the clinicians
- Strategies to reduce recidivism
- Targets difficult to treat populations

What is DBT?

- Behavioral treatment approach
- Uses dialectical thinking
- Focus on problem solving/skill building
- Embraces validation and change
- Highly Organized
- Easy to start
- Hard to master



Research Basis

- DBT more effective than TAU:
- Less likely to drop out of treatment
 - Fewer suicidal/self-injurious behaviors
 - Less medically severe behaviors
 - Less hospitalizations
 - Fewer hospital days
 - Less substance abuse

(Linehan et al., 1991)

DBT Assumptions

1. Pts are doing the best they can
2. Pts want to improve
3. Pts need to do better, try harder, be more motivated
4. Pts may not have caused all their problems, but they have to solve them anyway
5. Pts' lives are currently unbearable
6. Pts must learn new behaviors
7. Pts cannot fail in DBT

Standard DBT Treatment Structure

1. Individual Therapy
2. Skills Group
3. Telephone Consultation
4. Consultation Team

Skills Training Modules

- Mindfulness
- Emotional Regulation
- Distress Tolerance
- Interpersonal Effectiveness

What Behaviors Might DBT Target

- suicidal/self-injurious behavior
- evidence of bradychardia
- orthostatic blood pressure
- electrolyte imbalances
- EKG abnormalities
- ipecac

When to augment FBT

- Level of Care
- Medical Complications
- Co-morbid Conditions
- Level of Support
- Suicidality
- Behaviors
- Weight

Remember

- DBT and CBT may augment treatment, they are not an evidence based option to be used instead of FBT

Criteria for Therapists

- Evidence Based Care
- Correct Level of Care
- Focus on behaviors and weight
- Embedded in treatment system
- Presence of multidisciplinary team
- Communication with referring physician

Why Don't Providers all Practice Evidence Based Care

- Provider only trained in one kind of therapy
- Lack of Adherence
- Bias
- Over reliance on experience

Manuals

- Almost all evidence based care have them
- Should be comprehensible to provider and patient/family
- Evidence based care is not mysterious
- Evidence based care is not based on trust

How can I tell if I am getting Evidence Based Care

- For adolescents, it must start with FBT according to current literature for AN under 18, less than 3 years
- If FBT is not successful, it should be an adaption of evidence based care in other areas of childhood psychiatric illness or Adult Eating Disorders and it should still include FBT
- In adults it is CBT, IPT or DBT. These are beginning to be adapted as adjuncts (not replacements) for adolescents when FBT alone is not successful. Research just beginning

How can I tell if I am getting Evidence Based Care

- Ask for the evidence
- Ask for the manual
- Ask what conferences your provider has gone to
- Ask about certification
- Ask about supervision
- Talk to resources like FEAST

Adherent Care

- Care should be adherent
- Care should come from the manual
- Family Therapy is not FBT
- Skills groups are not DBT
- Standard CBT is not a stand alone treatment for AN, although variations, including those of Fairburn, may be
- Much more research needs to be done

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