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Family-Based Treatment of a 17-Year-Old Twin Presenting with Emerging Anorexia Nervosa: A Case Study Using the “Maudsley Method”

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Abstract

This paper describes the successful application of family-based treatment (FBT) for a 17-year-old identical twin presenting with a four-month history of clinically significant symptoms of anorexia nervosa (AN). FBT is a manualized treatment that has been studied in randomized controlled trials for adolescents with AN. This case study illustrates the administration of this evidence-based intervention in a clinical setting, highlighting how the best available research was used to make clinical decisions at each stage of treatment delivery.

This paper describes the successful application of family-based treatment (FBT) (Lock, Le Grange, Agras & Dare, 2001) for a 17-year-old identical twin presenting with a four-month history of clinically significant symptoms of anorexia nervosa (AN). FBT is a manualized treatment that has been studied in randomized controlled trials (RCTs) for adolescents with AN (Eisler, Dare, Hodes, Russell, Dodge, & Le Grange, 2000; Le Grange, Eisler, Dare, & Russell, 1992; Lock, Agras, Bryson, & Kraemer, 2005; Russell, Szmukler, Dare, & Eisler, 1987). This case study illustrates the administration of this evidence-based intervention in a clinical setting, highlighting how the best available research was used to make clinical decisions at each stage of treatment delivery. The parents, patient, and sibling provided permission for de-identified case information to be used in this study; in addition, aspects of descriptive and clinical data have been altered to protect the anonymity of the family.

FBT for AN was originally developed and tested at the Maudsley Hospital in London, England, on a population of adolescents and adults, and was found to be particularly efficacious for patients 18 and younger with a three-year or shorter duration of illness both at one-year post-hospitalization (Russell, et al., 1987) and at five-year follow-up (Eisler, Dare, Russell, Szmukler, Le Grange, & Dodge, 1997). Since this seminal study, which provided initial evidence of FBT's utility in preventing relapse and facilitating continued improvement following inpatient weight restoration, FBT for adolescent AN has been subjected to further study in additional RCTs, open trials, and clinical case series. Collectively, this literature has demonstrated that FBT is effective for a full course of weight restoration (Eisler, et al., 2000; Le Grange et al., 1992; Lock et al., 2005) and that gains are sustained several years after treatment ends (Eisler, et al., 1997; Eisler, Simic, Russell, & Dare, 2007; Lock, Couturier, &

Agras, 2006). Further, a version of FBT in which parents are seen separately from their adolescent is superior to the traditional conjoint family therapy format for families with high levels of expressed emotion (Eisler et al., 2000; Le Grange et al., 1992). Also, an abbreviated, 10-session course of FBT is as efficacious as the manualized 20-session version (Lock et al., 2005); FBT is feasible and effective when administered by investigators other than its developers (Loeb et al., 2007) and it appears effective for children in addition to adolescents (Lock, Le Grange, Forsburg, & Hewell, 2006).

FBT for AN is manualized and a full description of the protocol has been published (Lock et al., 2001). In summary, FBT is designed to mobilize parents in helping their ill child ultimately achieve remission from AN. Restoring weight and returning the adolescent to her chronologically appropriate stage of physical and psychosocial development are the primary immediate goals of treatment. FBT assumes an agnostic stance with regard to etiology of AN, and actively works to reduce self- and other-directed blame in the family about cause of illness. Parents are seen as a resource for dismantling the individual and environmental factors maintaining the AN. Siblings are assigned a supportive role in treatment, and parents are required to work as a team. FBT consists of three phases encompassing approximately 20 sessions. In Phase I, parents take charge of their adolescent's eating, organizing and supervising all meals and snacks. An in-session family meal provides an opportunity for the therapist to observe the current family eating patterns and assist the parents in their new mission. Phase II, in which the parents transfer control over eating back to the adolescent, commences once the adolescent's weight crosses back over the diagnostic threshold for AN and conflict regarding eating is significantly reduced. Phase III transitions to termination and targets more general concerns of adolescent development as the AN recedes.

In the case presented in the current paper, the family consisted of monozygotic twins discordant for AN and their biological, married parents. While this family's positive response to treatment broadly represents a successful administration of standard FBT, several remarkable factors both at presentation and during the course of FBT merit highlighting in the report. First, the patient had continued, concurrent treatment with a psychodynamically oriented individual therapist whose case conceptualization and corresponding clinical prescriptions were discrepant with FBT. Second, there are a number of issues unique to having an unaffected identical twin, such as seeing a constantly visible image of oneself at a normal weight and concern over the other twin's risk for development of AN, given the substantial concordance for AN among monozygotic twins (Bulik, Sullivan, Wade, & Kendler, 2000). Also, there is the tendency on the part of the unaffected twin to function in a parental role toward her sister during the parents' absence, in light of the sisters' shared daily routine and history of a profound twinship bond. Third, the current case had an initial presentation of a clinically significant but technically subthreshold diagnostic profile.

Referral Information

Bella's mother contacted the Mount Sinai Eating and Weight Disorders Program (EWDP) in November of 2006 at the suggestion of her daughter's therapist and pediatrician. Six months prior to this, Bella began individual therapy to address her anxiety around academic performance and her perfectionistic tendencies. Bella's therapist became concerned when she noticed that Bella had lost a significant amount of weight and initially referred her to a nutritionist. Bella had difficulty complying with the proposed meal plan and continued to lose weight. Bella's therapist then consulted with her pediatrician and referred her to the EWDP.

Assessment and Diagnosis

Presenting problem

Bella presented as a 17-year old Caucasian female whose parents brought her to treatment based on the collective concern that she was developing AN. Bella herself denied such a problem, reporting that she was merely trying to “eat healthier.” While the evaluation did not include full research-based measures, the diagnostic items from the Eating Disorder Examination (EDE) Version 15.0 (Fairburn & Cooper, 1993), a commonly-used semistructured interview for establishing eating disorder diagnosis and assessing severity (Pike, Roberto, Wolk, Gluck, & Walsh, 2008), were asked as part of the assessment. The EDE, which requires extensive training to administer and, in its complete form, takes approximately one hour to administer, is not typically used in non-research, clinical settings. The therapist also posed modified EDE diagnostic questions separately to the parents to assess their observation-based impressions of their daughter’s symptoms (Loeb, 2005). Height was measured with a stadiometer and weight with a digital physician’s scale. Body mass index (BMI; weight in kilograms / the square of height in meters) was calculated and compared against CDC BMI-forage growth chart norms to assess percentile as well as percent ideal body weight, with weight corresponding to 50th percentile BMI for age and gender (Bella’s modal growth curve percentile in childhood and adolescence) as the reference point for ideal weight. In cases where a patient’s normal pre-morbid growth trajectory has deviated consistently from the 50th percentile, the weight at the percentile corresponding to the patient’s individual history is used as the reference point for ideal weight in our program.

Bella and her parents reported that she had lost 14 pounds over the previous 4 months, dropping from 116 pounds at a height of 62” (representing a BMI of 21.3, within normal range, a percentile of 54.5, and a percent expected body weight of 102%) to her current weight of 102 pounds (BMI 18.7, 19.5th percentile, 89.5 % expected body weight), with the majority of the weight loss occurring over the first two months of dieting. Her last menstrual period was 10 weeks prior to presentation. Bella had been restricting both the quality and quantity of food that she ate, and she particularly avoided consuming carbohydrates, with the exception of fruit. Bella admitted that she was eating less than what her nutritionist prescribed and that she adjusted the food plan to accommodate both her “small bone structure” and reduced energy expenditure since her soccer coach, under orders from the school administration, limited her sports participation. When questioned directly, she denied a fear of weight gain, stating that she simply has a strong aesthetic preference for her current weight and shape compared to her twin sister’s body. When asked if they have reason to believe their daughter experiences a fear of weight gain (e.g., by her report to them or based on any probable manifestations of this symptom that they may have witnessed), the parents cited several behavioral indicators of fear of weight gain that they have observed in Bella, including statements such as “You’re just trying to make me fat!” when encouraged to eat a normal meal, a highly restrictive diet (i.e., fewer than 600 kcal/day), and a panicked reaction when her pediatrician told her he would like to see her gain at least one pound before their next appointment. When asked about body image disturbance in their daughter, the parents reported that Bella made repeated remarks concerning her “wide hips” and “huge thighs” and regarded herself as “fat.” Bella’s own report was consistent with her parents’ endorsement of these items.

The information obtained in this evaluation, based on Bella’s self-report and collateral data obtained from the parents, pointed to a clinical diagnosis of AN, restricting type. Notably, Bella might not have met criteria for AN in the context of a research protocol, which typically interprets DSM criteria more stringently and relies on strict weight cut-offs and direct patient endorsement of the cognitive criteria. With regard to DSM-IV Criterion A for AN [“Refusal to maintain a body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected...)”] (APA,

2000), Bella's percent expected body weight was just below 90%. Bella denied Criterion B ("Intense fear of gaining weight or becoming fat, even though underweight"), but her parents reported several behavioral indicators of fear of weight gain that they have directly observed, illustrating the importance of using multiple informants and behavioral observation to complement self-report in arriving at a psychiatric diagnosis for children and adolescents. Criterion C ("Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight") was met by virtue of Bella's description of her overall shape and specific body parts. In addition, she denied the seriousness of her weight loss, despite the significant concern raised by her doctors, parents, and school. Bella's last menstrual period was 10 weeks ago, and the treatment team predicted that she would imminently meet Criterion D, which requires the absence of at least three consecutive cycles. Bella denied objective binge eating and purging but did admit to subjective binge eating episodes for which she compensated by engaging in excessive levels of exercise.

Bella had never been hospitalized for her eating disorder; however her pediatrician sent her to the emergency room in September 2006 for dehydration. Bella denied a history of other psychiatric disorders or significant psychiatric symptoms, including depression and suicidality.

Psychosocial history and family functioning

Bella reported that she had a "great" relationship with her family and that she was extremely close to her identical twin sister, Kayla. Bella achieved excellent grades in school, and described a social network consisting of her sister and their four "best friends." Bella appeared slightly introverted during the evaluation, although she and her parents reported that Bella was the "more outgoing twin." Her parents stated that they had raised their daughters as individuals (e.g., never dressing them alike, following their elementary school's advice to place them in separate classrooms), but that Bella and Kayla had always identified and related as twins and had a unique form of communication when they were younger.

The parents reported that Bella's eating pathology had been extremely stressful on the entire family, and both parents expressed deep concern about the welfare of their child. Bella's parents appeared to have a good relationship with one another, and were committed to jointly helping their child achieve a healthy weight. They did express concern about fulfilling their professional responsibilities while participating in FBT. The parents' psychiatric histories were significant for obsessive compulsive disorder in the mother and major depression in the father.

Treatment Plan

The therapist recommended FBT for Bella and her family. Per FBT protocol, the therapist requested that all family members, including the unaffected twin, Kayla, attend all treatment sessions. Since the clinical assessment did not suggest high levels of criticism in the family, the therapist planned on seeing the parents and adolescent conjointly. This decision is consistent with research on the moderating effects of expressed emotion in FBT, wherein highly critical families have been shown to achieve a better outcome in a separated format of the approach (Eisler et al., 2000; Le Grange et al., 1992). Bella's pediatrician deemed her medically stable and provided clearance for outpatient treatment with biweekly medical monitoring.

With regard to her other concurrent treatment, the therapist supported Bella's wish to continue in individual psychotherapy, and, after obtaining a release to exchange information, spoke to the individual therapist at length. Her own case conceptualization characterized the AN symptoms as arising from Bella's dual challenge for successful individuation, representing a maladaptive attempt to both separate from her parents and differentiate from her twin sister. Moreover, the individual therapist had previously suggested that the parents refrain from any

involvement in Bella's eating, consistent with more traditional philosophies of AN treatment based on etiological theories of familial enmeshment and personal control. She was particularly concerned with the appropriateness of FBT for a late adolescent. However, she was willing to support the radically different approach within FBT, agreeing that hospitalization for AN – which the pediatrician was considering as an alternative – would be potentially more disruptive to Bella's psychosocial development. The two therapists spent much time determining how the individual therapist would discuss and process FBT with Bella since it represents a diametrically opposed approach to what she initially prescribed. The family therapist explained the atheoretical nature of FBT and that she would not be presenting an alternative etiological model of the development of Bella's eating disorder. While the strategies inherent in FBT may imply a discrepant etiological theory, the explicit messages are of blame reduction between the parents and child and of mobilizing the parents as the key resource in achieving wellness for their ill daughter. The individual therapist was most comfortable being honest with Bella about her wish to see Bella reverse the weight loss outside of the hospital and about her recognition of the positive outcomes associated with FBT, while refraining from conveying her doubts about the treatment. The two therapists agreed that neither would express even subtle disagreement with the other's tactics to Bella or her parents, and also decided to speak on a weekly basis to ensure coordinated care, and to reduce the likelihood of splitting.

After several discussions between the therapist, Bella, her parents, and the treating nutritionist, the family determined that they would temporarily suspend nutritional counseling out of concern regarding intervention compatibility and "mixed messages" during Phase I of FBT, in which the adolescent is not expected to independently and willingly follow nutritional recommendations. However, the parents decided that they would consult with the nutritionist during Phase I if they needed assistance in determining how to best accomplish Bella's weight restoration from a nutritional perspective. Bella did not object to postponing her next nutritional counseling session but vehemently objected to the notion that her parents would be directing her food consumption for a period of time. Nevertheless, she assented to participate in FBT.

Course of Treatment

Session one

In FBT, the therapist begins each session by weighing the patient alone and discussing with the adolescent whether there are any issues she would like help or support raising in the family session. The weight is reviewed openly with the parents, but the adolescent can elect to report the weight or have the therapist do so. Bella lost 3.5 lbs between the evaluation and Session 1, rendering her at 86.35% expected body weight. She was pleased with the weight loss, but anxious about her parents' reaction, stating that she doesn't want them to worry. Bella also expressed concern that her pediatrician would hospitalize her if her weight continued to decrease. When the parents and sister joined the session, the therapist marked the new weight on a graph, showing how close Bella was to the cutoff for full AN.

Per the manual, the therapist commenced FBT with a somber family session to convey both the seriousness of the illness and that it is external to Bella herself. The purpose of these dual maneuvers is to heighten parental anxiety to the point of mobilization while reducing blame for illness directed toward the adolescent. This is crucial so that the parents can facilitate weight restoration effectively and without anger. Moreover, the therapist in FBT is explicit that the cause of AN is not known, thereby mitigating parental self-directed blame. In addition to highlighting the medical and psychological risks inherent in each of Bella's AN-like symptoms (e.g., the risks of a highly restrictive diet, of precipitous deliberate weight loss, of restriction-induced oligomenorrhea, etc.), the therapist also emphasized that given Bella's steep and consistent weight loss trajectory, her eating disorder had a strong potential to progress to full-blown AN, a pernicious and sometimes deadly disorder. The therapist used the analogy of the

eating disorder as an octopus whose tentacles have taken hold and are squeezing harder and harder over time. This emphasis of risk *for* AN, beyond the risks *of* AN, was the only modification to the manual necessary to address Bella's technically subthreshold presentation, which is more likely to represent an artifact of our current diagnostic system than a truly distinct clinical state (WCEDCA, 2007). She also raised the issue of the family having a narrow window in which to resolve the eating disorder before college next fall.

Another goal of the first session of FBT is to take a history of how the eating disorder has affected each family member. This process provided Kayla with an opportunity to express how worried she was about her sister, how this is the only aspect of Bella she does not understand, and how alienated she feels from her twin. The parents admitted that the majority of their attention and resources have been directed to Bella recently, but Kayla was quick to deny any resentment toward her sister for this. When the therapist charged the parents at the close of Session 1 with the task of actively reversing Bella's weight loss, Kayla immediately offered to help during lunches at school or times when their parents were unavailable. The therapist was clear that Kayla's role was strictly to be supportive of Bella, and proscribed a supervisory or parental role for Kayla in the course of Bella's nutritional rehabilitation. The therapist also emphasized that while weight gain would be essential to the resolution of Bella's eating disorder, general normalization of eating behaviors is equally essential, even beyond its utility in directly facilitating weight restoration. The parents were encouraged to re-introduce foods that Bella had recently deemed forbidden, both for their caloric value in accomplishing weight gain and to directly challenge the rigid food practices dictated by Bella's eating disorder.

The final instruction in Session 1 is for the parents to bring in a picnic meal for the family to the next session. The therapist stated, "In deciding what to bring for Bella to eat, consider her degree of weight loss and how you want to help her eat normal, healthy amounts of food again. Please include at least one food that she used to like but has stopped eating." The parents became anxious about the details of this task, as well as about the larger job of resolving Bella's eating disorder symptoms. They asked the therapist for a meal program so that they could plan the picnic, as well as Bella's daily food consumption from this point forward. The therapist sensitively explained that every family approaches these tasks differently and that while the therapist has expertise in AN, the parents have expertise in their daughter and family. The therapist encouraged Bella's parents to use common sense in determining the quantity and quality of her food, as well as the frequency of eating, stating, "You successfully fed and raised two healthy daughters, and then this illness struck Bella. Don't be intimidated by the eating disorder or by the resistance that it will generate. Consider how you might feed Bella if she were underweight because of a medical condition." This is consistent with the goal in FBT to empower parents. Moreover, the therapist refrained from providing more specific and directive instructions for the picnic meal, as observing if and how the basic missive was followed is an important part of the assessment that takes place in Session 2.

Session two

Bella lost another 2.7 lbs between Sessions 1 and 2. In addition, she had missed a third menstrual period. Together, the persistence of weight loss and amenorrhea now placed Bella fully within the parameters for a diagnosis of AN. When this was discussed as a family, the mother started crying, stating that she had been desperately trying to get Bella to eat since the last session, but that nothing seemed to be working. The father reported that he had been on a business trip for most of the week and that he felt guilty for the extra burden this placed on his wife for implementing the new plan. Using language consistent with the FBT goal to externalize the illness, the therapist explained that the AN was clever and was trying to thwart the parents' efforts, and that like a parasite, it viewed Bella as a host for its own survival without a care for

her suffering. The therapist reassured the parents that they would use today's session and the picnic meal as an opportunity to refine their strategies.

One of the goals of Session 2 is to assess the family process with regard to eating. The therapist's questions revealed that the mother had prepared the meal with consideration for her husband's cardiovascular health diet, as well as with input from Bella, which was typical for the family in recent months. All family members participated in setting the table and laying out the food. The meal consisted of Caesar salad with fat free dressing and fat free croutons, grilled chicken breasts, whole grain rolls, fruit salad, and bottled water. The mother reported that the dressing, croutons, and rolls represented items that Bella currently avoided, and that when she reviewed the menu with Bella in advance of the session, Bella successfully negotiated for a fat-free salad and whole grain bread. Bella had cried when her mother suggested bringing brownies, previously her favorite dessert. The parents and Kayla served themselves, while Bella sat with an empty plate until her father placed an array of foods on it. Bella cut her food into small pieces and slowly ate approximately one-fourth of her chicken breast and the watermelon from her fruit salad while the remainder of the family ate normal portions of the full array of foods. When the parents encouraged Bella to eat more, she protested, stating that she was full. The parents reported that this pattern represented a typical dinner at home.

The therapist provided feedback on the meal process, explaining that by negotiating with the AN regarding meal selection, only the illness will triumph; that trying to accomplish weight gain with low-fat foods will make the course of weight gain longer and more arduous. The therapist further stated that she is confident that the parents can make good decisions about the quantities and types of food that will eradicate the AN. She reminded the parents that AN has a mortality rate that rivals some cancers, and that food is medicine in this case. She then asked the parents to convince Bella to eat at least one more bite of food, which represents the key intervention in Session 2 and an opportunity for direct coaching by the therapist as necessary. The therapist reminded Kayla that she was there to be a support to Bella.

The parents asked Bella to eat a bite of the roll and she refused, stating again that she was full. Kayla immediately offered to take a matching bite, asking Bella if it would help if Kayla did this along with her. The parents told Kayla that they appreciated her solidarity with Bella, but that Bella will need to eat a substantial amount to gain weight and they do not expect Kayla to do the same. Kayla then took Bella's hand and held it for the remainder of the session.

With minimal additional coaching from the therapist, and a judicious blend of firmness and kindness, Bella's parents accomplished the task of convincing her to eat the bite of the roll. In response to Bella's protests that she was too old to be fed and it was her choice to be thin, Bella's parents responded that they were stepping in where Bella was not able to adequately care for herself, and would not let her choose to be ill. The therapist also reminded the family that Bella's developmentally appropriate level of autonomy in other psychosocial domains was to be preserved, and that her parents were taking control exclusively in relation to her AN – and that this was to be tapered in Phase II of FBT and ultimately stopped.

Remainder of phase I (sessions 3-7)

While the FBT manual allows for 10 sessions to complete Phase I, Bella's family required 7, speaking both to the discrepancies between intervention protocols and naturalistic clinical course, as well as to the efficacy of shorter-term FBT as demonstrated in clinical research (Lock et al., 2005). She gained a mean of 1.7 lbs per week in the remainder of Phase I. Given her initial loss, she did not surpass her evaluation weight until Session 6. At Session 7, she had reached a weight of 106 lbs, corresponding to a BMI of 19.4, a growth curve percentile of 29.5, and a percent expected body weight of 93. Notably, the transition to Phase II, in which control over eating is gradually transferred back to the adolescent, does not presume full weight

restoration, but rather weight at a minimum of 87% expected (i.e., above the diagnostic threshold), in combination with reduced conflict around eating and increased parental empowerment. In Bella's case, the weight criterion was met by Session 5, but the full complement of transition criteria was not achieved until two sessions later.

The remainder of Phase I of Bella's treatment included the following topics and strategies. First, the father limited his business travel as much as possible. When he was away, he participated in decisions about Bella's meals by phone. He also attended Session 4 by speakerphone. Bella's mother decided to let her colleagues know that one of her daughters was ill and that she would need to reduce her working hours accordingly for a period of time. Bella's parents also enlisted the help of the school nurse to monitor her lunches. Kayla ate with her as well, but was not put in the position of supervising the meal or reporting what was eaten to her parents. This was in response to Kayla's continued tendencies to assume the parental role, especially at school. The parents also worked out with the school that Bella could return to the soccer team during Phase II of treatment. This served as a significant incentive for Bella in the weight gain process. The parents had a recurring disagreement about the amount of food Bella should be asked to eat, with the father expecting more than the mother. The therapist encouraged the parents to work this out privately and always present a united front to Bella. The parents did not consult with Bella's nutritionist during Phase I. Initially, Bella insisted on knowing all the ingredients and food preparation details of her meals and snacks. Her parents complied, but hid certain information to reduce Bella's anxiety. When Bella discovered their misrepresentation, she was angry and resolved to restrict her eating further. The parents altered their strategy to respond to Bella's request for such information either with complete honesty or by reminding her that they were making decisions about what would most effectively battle the AN at a time when she could not make such decisions for herself.

In Phase I, the parents requested a private session with the therapist to discuss issues pertaining to Kayla. Since both conducting a separated session and devoting a Phase I session to concerns about another family member represent protocol deviations, the therapist and parents compromised by being open with Bella and Kayla that such a session would be taking place and about the general topic of the meeting. The parents had read about the heritability of AN and feared for Kayla's risk for developing AN. They were especially concerned given that Bella's outbursts had included statements such as, "You're trying to make me fat like Kayla!" which Kayla had heard at least once in a family session. The parents had discussed with Kayla that this was the AN speaking, not her sister, but they felt that simply externalizing the illness was an insufficient response. They were also worried about the effect the negative body comparison was having on Bella and Kayla as individuals and as sisters. For example, each twin expressed extreme guilt after the outburst in session, Bella for insulting Kayla, and Kayla for raising Bella's anxiety by functioning as a mirror. While FBT is designed to reduce anger and resentment on the part of siblings, the parents believed that Kayla was not exhibiting healthy levels of these emotions. The parents ultimately offered Kayla her own therapy to address her individual needs, which Kayla accepted.

Phase II (sessions 8-10)

Session took place approximately biweekly in this phase of treatment. Bella gained 1 lb per week, ending Phase II at 113 lbs (BMI 20.7, growth curve percentile 47.4, 99% expected body weight). It is not uncommon for the rate of weight gain to decrease in Phase II as a function of reduced parental supervision and, as in Bella's case, a reintroduction of physical activity. In consultation with the therapist at Session 8, the parents decided to make an agreement with Bella that she could play soccer only if her weight continued to increase. The parents informed Bella that her daily food intake would need to increase to offset her physical activity. Bella chose to add to her afternoon snack and dinner. The parents decided to remain in control of the

food for her first week of sports, and then assuming that she made the necessary gains, to gradually give Bella more responsibility with food. This gradual process started off with the mother supervising Bella make her own breakfast, then plan her lunch, and serve herself at dinner. This worked well, and by the end of Phase II, Bella was eating independently and having dinner with friends several times per week.

College acceptances were a major theme during the later part of Phase II. Bella and Kayla had applied to and were accepted to the same colleges, and they were trying to decide whether or not to separate for the next four years. They eventually chose to attend their mutual top choice university. Between Sessions 9-10, Bella's menses returned. By Session 10, Bella also reported a significant decrease in concern over her weight and shape, and a renewed interest in social activities including dating. The parents and Kayla corroborated this, and the family expressed how relieved they were to be at this stage of treatment.

Phase III (sessions 11-12)

Sessions were spaced monthly during Phase III, per the FBT protocol, but there were only two sessions, at the family's request, because of the twins' summer and college plans. Between Sessions 10-11, Bella had lost two pounds, to 111. This frightened all family members, including Bella, who resolved to eat more. She stated that she hadn't realized how vigilant she needed to be about her eating and that she hadn't been consciously restricting her food intake. The therapist emphasized the importance of avoiding any weight loss, deliberate or non-purposeful, as either could trigger a relapse. By Session 12, Bella had regained the lost weight plus 0.8 additional pounds, ending treatment at 100% of expected body weight (weight 113.8, BMI 20.9, growth curve percentile 49.4), and just over two pounds shy of her baseline weight. Since all functional markers were intact, the family decided to not push the weight back to 116. Her menses was regular, and she no longer met the psychological criteria for AN, either by self- or parent-report. However, she remained sensitive to her weight and expressed a strong preference to remain within this range. In addition to addressing issues of late-adolescent development, these final sessions focused on how Bella and her parents would best identify and manage any potential relapses during the college years.

Six-Month Follow-Up and Summary

Bella was medically monitored by a physician at college, but chose not to continue in psychological treatment. Her symptom status was generally stable. A vacation home revealed a two-pound weight loss. Erring on the side of caution, Bella and her parents did not want to attribute this to normal weight fluctuations, and agreed that the weight should be actively regained. Bella was successful in this with her parents' support, but not supervision. She reported enjoying college life. She and Kayla chose separate dormitories and different majors.

Bella's outcome is consistent with results achieved in published RCT data on FBT, and her weight and menstrual status at termination place her in the best of three categorical outcomes applied in Maudsley studies (Eisler et al., 2000; Le Grange et al., 1992; Lock et al., 2005; Russell et al., 1987). Weight was chosen as the primary objective measure of treatment progress because early weight gain in the course of FBT predicts remission (Lock, Couturier, Bryson, & Agras, 2006), and weight is the least vulnerable to patients' denial or distortion among the complement of diagnostic criteria for AN. The psychological criteria for AN may be denied or minimized (e.g., Couturier & Lock, 2006) by virtue of motivated deception, lack of insight, or, in the case of children or adolescents, because of developmental limitations in cognitive capabilities necessary to endorse abstract concepts. Similarly, tracking changes in "denial of seriousness of low body weight" may not be valid for younger patients because it is normative, not pathological, for adolescents to exhibit deficits in risk appraisal relative to adults (Boyer, 2006), particularly for distal outcomes. (For a review of challenges in child/adolescent

identification and classification of eating disturbance, see WCEDCA, 2007). This case suggests that concurrent individual psychodynamic treatment is compatible with FBT provided that the individual therapist agrees that FBT should be implemented and the two therapists communicate frequently, although its specific effect on outcome is unknown. Moreover, the success of FBT does not require that the individual therapist relinquish a distinct case formulation or personally subscribe to the approach. Finally, this report highlights the importance of early intervention for a disorder as serious as AN.

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