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Eating With An Anorexic Child: A Controversial Treatment

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War broke out on the day Rina Ranalli and her husband told their 12-year-old anorexic daughter the strict new house rules: three meals and three snacks a day. Chicago's Ranalli family was using the little-known Maudsley Approach, a grueling but evidence-based treatment for adolescents suffering from the eating disorder anorexia nervosa. The approach, also called "family-based therapy," flips conventional treatment on its head. Often parents are advised to put their starving child in therapy or residential treatment, distance themselves to preserve the teen's independence and wait for the day the child decides to resume eating.

The Maudsley Approach has something other remedies for anorexia do not: A modest body of clinical evidence suggesting that most adolescent patients respond favorably after relatively few treatment sessions. For parents, it's a glimmer of hope for a serious illness still lacking a gold-standard treatment.

Just five randomized, controlled studies have examined the treatment of anorexia in adolescents, according to Daniel le Grange, Ph.D. (left), Professor in the Department of Psychiatry & Behavioral Neuroscience, and Director of the Eating Disorders Program, at the University of Chicago. Four of the five published studies include family-based therapy, or the Maudsley Approach. Though the studies are small, they indicate that early treatment with Maudsley boosts a child's chance of getting a handle on the illness. Maudsley has also been found to be effective for those who don't yet have full-blown anorexia but are teetering on the edge. "A weight gain of 3 to 4 pounds in the first month of treatment gives an 80 percent certainty of good outcome," said le Grange, who helped develop the approach at London's Maudsley Hospital and brought the treatment to the U.S. The success rate drops considerably for children who don't quickly gain weight during treatment. But le Grange argues that given Maudsley's promising results — and limited comparative data — the family-based treatment should be the first-line intervention instead of an alternative for adolescents who qualify for outpatient care. "To be really honest with families, we should say: 'We only have one treatment. There is a fair amount of evidence, and it's what you should start with,'" le Grange said. "If clinicians are not willing to do that, then we have to agree we're just improvising."

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