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BRIEF REPORT

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A pilot study of multifamily therapy group for young adults with anorexia nervosa: Reconnecting for recovery

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Abstract

Objective: We tested the feasibility, acceptability, and preliminary effect sizes on outcome measures of Reconnecting for Recovery (R4R) Multifamily Therapy Group for young adults with anorexia nervosa (AN).

Method: Ten participants (mean age = 23 years, *SD* = 3.6) meeting Diagnostic and Statistical Manual of Mental Disorders 5th Edition criteria for a restrictive eating disorder (AN or other specified feeding and eating disorder) and 14 family members received 16 R4R outpatient sessions over 26 weeks. Feasibility and acceptability were evaluated by recruitment and retention rates and patient/family member suitability scores. Outcomes were determined utilizing the Eating Disorder Examination (EDE), weight (body mass index), and Difficulties in Emotion Regulation Scale.

Results: All participants and 12 family members were retained, and the majority found R4R acceptable. EDE global score and lack of emotional awareness improved significantly from baseline (BL) to end-of-treatment (EOT) and BL to 6-month follow-up (6MFU) with moderate to large effect sizes (0.47–1.41). Limited access to emotion regulation strategies (LAERS) improved significantly from BL to 6MFU (moderate effect size; 0.57). Improvements in LAERS from BL to EOT (0.32) and weight from BL to EOT and BL to 6MFU were not significant (effect sizes 0.16–0.22).

Discussion: Findings provide preliminary evidence that R4R is feasible, acceptable, and produces clinically significant changes in targeted outcomes.

KEYWORDS
anorexia nervosa, eating disorder, multifamily therapy group, young adults

1 | INTRODUCTION

Anorexia nervosa (AN) is a serious psychiatric disorder occurring primarily during adolescence and young adulthood (Kaye, Fudge, & Paulus, 2009; Walsh et al., 2005). Despite AN's high mortality, morbidity, and chronicity (Berkman, Lohr, & Bulik, 2007; Papadopoulos, Ekbom, Brandt, & Ekselius, 2009), there is little empirical support for its definitive treatment in young adults (Zipfel, Giel, Bulik, Hay, & Schmidt, 2015). The most recent randomized controlled trial for adult AN (Byrne et al., 2017) revealed no statistically significant differences between treatments on clinical outcomes at end-of-treatment (EOT) or follow-up. Outcomes were modest at best, supporting the need for continued efforts to improve outpatient treatment. Two studies have explored adaptations of adolescent family-based treatment (FBT) with young adults (cf. Chen et al., 2016; Dimitropoulos et al., 2018). Findings from both these open trials revealed improvements in body mass index (BMI) and eating disorder (ED) psychopathology at end of treatment and follow-up, providing preliminary support for the involvement of parents in recovery.

Although individual therapy approaches and FBT for young adults with AN have shown promise, the illness remains difficult to treat.

This challenge may relate to the interplay of *intrapersonal* (e.g., poor emotion regulation [Lavender et al., 2015]) and *interpersonal* (e.g., avoidance of intense emotion [Schmidt & Treasure, 2006]) *processes of disconnection* characterizing AN (Tantillo, Sanftner, & Hauenstein, 2013). The interplay of disconnections from self, one's body, and others can amplify *interpersonal disconnections* with family members who experience distress and high caregiving burden (Zabala, Macdonald, & Treasure, 2009.) Individuals with AN may engage in symptoms to cope with these disconnections, unwittingly perpetuating the illness (Schmidt & Treasure, 2006).

Research suggests that the outcome of AN is influenced by interpersonal disconnections with close others (Zabala et al., 2009), and recovery from AN is related to improvements in social functioning (Lowe et al., 2001) and quality of relationships (Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). Therefore, strengthening emotional and relational skills required to identify and repair disconnections may improve AN outcome.

Multifamily Therapy Group (MFTG) for young adults with AN holds promise because it creates a sustainable, *diverse* therapeutic community skilled in identifying and repairing disconnections related to AN. Unlike individual and group treatments, patients and families have the opportunity to learn together, capitalizing on one another's perspectives and strengths (McFarlane, 2002; Simic & Eisler, 2015; Tantillo, McGraw, Hauenstein, & Groth, 2015).

MFTG commonly involves five to seven patients and their families and has been successfully used as a primary or adjunctive treatment for young adults with chronic behavioral health problems (e.g., schizophrenia, depression, and substance use) and adolescents with AN. MFTG outcomes including cost-savings and improvements in clinical symptoms and family functioning for both of these groups are well established (c.f. Gelin, Cook-Darzens, & Hendrick, 2017; McFarlane, 2002; Eisler et al., 2016). A recent pilot study of a MFTG developed specifically for young adults with AN (Dimitropoulos, Farquhar, Freeman, Colton, & Olmsted, 2015) found this treatment feasible and acceptable, producing improvements in ED psychopathology, weight and mood, and decreasing negative caregiving appraisals and expressed emotion.

The lack of research on MFTG for young adults with AN, and its promise, underscore the need for the current pilot study. To this end, we examined feasibility and patient/family acceptability of *Reconnecting for Recovery* (R4R), a relational/motivational outpatient MFTG informed by prior work from the first author (Tantillo, 2010; Tantillo et al., 2015). We also aimed to establish preliminary effect sizes for the impact of the group on the primary (ED psychopathology) and secondary (weight and emotion regulation) outcomes.

2 | METHOD

2.1 | Participants and procedure

Participants were 10 young adults, ages 20–31 years, who met ||Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM 5; American Psychiatric Association, 2013) criteria for AN or other specified feeding and ED's (OSFED; including atypical AN). Patients were deemed medically stable by their primary care provider (PCP) and continued to see their PCP to ensure medical stability. Patients continued outpatient treatment, if already in such care. All participants provided written informed consent. This study was approved by the University of Rochester's Institutional Review Board.

Authors (M.T. and J.B.), not involved in treatment delivery, trained in administering the ED measures, and jointly conducted all assessments. Feasibility and acceptability of R4R were assessed via examining recruitment and retention, and the perceived treatment suitability score from the patient/family member suitability and expectancy measure. The latter (c.f. Lock et al., 2010) is rated on a Likert scale (0–10) and administered at end of Session 1 and EOT. All outcome measures were administered at baseline (BL; start of group), EOT, and 6-month follow-up (6MFU).

BMI was calculated using height/weight obtained at BL and weight at each assessment. Additional measures included the ED examination (EDE; Cooper & Fairburn, 1987) and Lack of Emotional Awareness (LEA) and Limited Access to Emotion Regulation Strategies (LAERS) subscales of the Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004). LEA evaluates the ability to attend to and acknowledge emotions. LAERS assesses the belief that one can access effective emotion regulation strategies to manage situations. Patients and family members completed a brief demographic form. Patient psychiatric comorbidity was assessed using the Mini-International Neuropsychiatric Interview (Sheehan et al., 1998).

Two master's prepared ED MFTG therapists cofacilitated two R4R MFTG cycles (five patients with up to four of their respective adult family of origin or choice members [e.g., partner and close friend]). They received a full day training from M.T. regarding R4R and young adult development prior to conducting R4R, as well as weekly supervision (written and verbal feedback) in response to M.T.'s review of each video-recorded MFTG session.

2.2 | R4R MFTG intervention

R4Ris a 16-session MFTG manualized intervention combining psychoeducation, homework assignments, and small and large group discussion. Each 90-min session was offered over 26 weeks (see Table 1 for session frequency and topics). R4R focuses predominantly on development of emotional and relational processing skills required to identify and repair disconnections associated with AN and young adult recovery challenges (Tantillo et al., 2015). Study manual and protocols are available from the first author upon request.

2.3 | Statistical analyses

In order to evaluate the feasibility and acceptability of R4R MFTG, we examined the number of patients/families who (a) expressed interest in participating; (b) enrolled (i.e., treatment feasibility); (c) completed at least eight sessions (i.e., treatment engagement); (d) completed group (i.e., treatment retention); and obtained patient and family member evaluations of treatment acceptability. Paired samples *t* tests, and within-patient standardized effect sizes, were used to evaluate

TABLE 1 R4R multifamily therapy group session topics

Session topics	Goals
1 and 2: Assessment, orientation, and joining[a]	- Assess quality of connections, relational patterns related to AN's impact on patient and family, disconnections, and eating disorder symptoms, triggers, meanings, and purposes
3: AN: A disease of disconnection—introduction, recovery process, and the spiral of change[a]	- Icebreaker and orientation to R4R group - Reframe AN as a disease of disconnection - Increase connection and universality - Describe spiral, stages, and processes of change and motivational interviewing principles to foster patient motivation - Discuss strategies for connection (ongoing homework) - Help with identifying and expressing emotions
4: Recovery process, the spiral of change, and motivational interviewing (continued)[a]	- Small and large group discussion where patients are on spiral of change - Continue discussion about spiral of change and motivational interviewing principles - Describe continuum and levels of care for AN, available local help, treatment team roles and functioning, and nature of recovery
5: Biopsychosocial risk factors for AN and comorbidity[a]	- Psychoeducation about biopsychosocial factors related to development and maintenance of eating disorders, as well as information about comorbidity - Discuss the *intrapersonal and interpersonal* processes of disconnection related to AN and how their interplay can contribute to interpersonal disconnections and adversely influence recovery
6: Disconnections and functional analysis skills[a]	- Continue to discuss how interplay of internal and interpersonal disconnections can perpetuate eating disorder symptoms - Discuss the five good things about mutual relationships and the importance of being different-in-connection - Small group work to complete functional analysis and identify AN triggers and purposes
7: Strategies to promote mutual connections[a]	- Large group discussion of functional analysis - Discuss ways to meet needs without AN - Strategies to strengthen connection while being open to internal and interpersonal differences (feelings, thoughts, needs, etc.)
8: AN and the family context: Rules and relationships[a]	- Small and large group work to identify implicit and explicit rules related to AN, recovery, and relationships - Use criteria to evaluate helpfulness of rules for recovery and relationship with self and others. Do they help us embrace or avoid difference?
9: Points of tension and disconnection: AN and relationships[a]	- Small and large group work identifying points of tension and disconnections (created and maintained by AN)-related to illness, recovery, and relationships - Construct a group list of above - Review strategies that repair disconnections and strengthen connection to self and others
10: Nourishing and empowering the "we" in relationships[a]	- Large group discussion of selected points of tension and disconnections from list generated in Session 9 - Identify forces (AN, culture, gender, development, and personality) that contribute to disconnections - Practice emotional and relational skills to repair disconnections and strengthen mutual connections
11: Waging good conflict in connection[b]	- Large group discussion of selected points of tension and disconnections from list generated in Session 9 - Continue practicing emotional and relational skills to repair relationships and strengthen mutual connections - Practice being different-in-connection (being connected with self AND others)
12: Moving from disconnection to connection[b]	- Small and large group work to identify interpersonal disconnections and points of tension specifically related to transition from adolescence to adulthood and achieving adult developmental milestones - Identify earliest signs that AN is trying to solve tension/anxiety: young adult developmental challenges - Discuss alternative coping strategies and needed support from others - Practice emotional and relational skills to repair relationships and strengthen mutual connections
13–14: Relapse prevention, maintaining connections, and termination[b]	- Identify internal and external triggers and cues and relapse prevention strategies - Small and large group work discussing pros/cons of caregiving styles and their impact on recovery - Identify effective caregiver responses (being a St. Bernard or dolphin) - Discuss continued treatment and support after R4R to meet needs and recovery goals - Facilitate discussion of termination themes

(Continues)

TABLE 1 (Continued)

Session topics	Goals
15–16: Relapse prevention, maintaining connections, and termination[c]	- Discuss challenges and successes. Positively reinforce adaptive emotional and relational skills - Identify triggers, early internal/external cues including emotions, and relapse prevention strategies - Review points of tension/disconnections and strategies for repairing disconnections - Identify effective caregiver responses - Identify supports who will foster recovery and how to use them - Facilitate discussion of termination themes, accomplishments, future goals, learning needs, and next steps - Briefly evaluate group and goodbyes

Note: Sessions 1 and 2 are single-family sessions; Session 3–16 are group sessions involving all patients and families.
Abbreviations: AN, anorexia nervosa; R4R, reconnecting for recovery.
[a]Weekly meetings.
[b]Biweekly meetings.
[c]Monthly meetings.

TABLE 2 Change from baseline to end-of-treatment and to 6-month follow-up: means, *SD*s, *p* values, and Cohen's *d* estimates

	Baseline	End-of-treatment	6-month follow-up	Baseline to end-of-treatment *p* value	Baseline to end-of-treatment Cohen's *d*	Baseline to 6-month follow-up *p* value	Baseline to 6-month follow-up Cohen's *d*
BMI	20.65 (3.32)	21.19 (3.315)	21.47 (3.88)	.258	0.16	.206	0.22
Eating disorder examination—global	2.76 (1.2)	1.77 (0.71)	1.28 (0.58)	.003	0.75	.002	1.41
lack of emotional awareness	15.3 (5.2)	12.9 (3.7)	12.95 (4.7)	.047	0.49	.04	0.47
Limited access to emotion regulation strategies	18.8 (6.9)	16.8 (2.3)	15.0 (4.9)	.315	0.32	.015	0.57

Abbreviation: BMI, body mass index.

change from BL to EOT and BL to 6MFU for ED psychopathology (EDE global score), body weight (BMI), and emotion regulation (LEA and LAERS).

3 | RESULTS

3.1 | Participant characteristics

Participants were 10 Caucasian women (mean age = 23 years, *SD* = 3.6, range 20–31). Seven lived with parents or other family members. Six were working full- or part-time, and four were full-time students. All participants had a DSM 5 restricting ED (six = OSFED and four = AN). Duration of illness ranged from 1 to 17 years (mean = 7.9, *SD* = 5.8). Mean EDE global score at BL was 2.76 (*SD* = 1.2). BMI ranged from 16.0 to 26.1 (mean = 20.7; *SD* = 3.3). Eight participants reported comorbid psychiatric diagnoses (seven = mood disorder, three = panic disorder, four = generalized anxiety, one = PTSD). Eight had previous treatment for ED's. Six were on psychotropic medication. At screening, five indicated they were in outpatient individual therapy.

3.2 | Feasibility and acceptability

Thirty individuals expressed interest in the study. Of 17 eligible participants, 14 were still eligible after completing the "in-person" screening, and 10 were enrolled. Of those who did not participate, two decided on an alternate form of therapy, one was unsure of making the time commitment, and one was unable to identify a family member.

Treatment engagement was positive with all patients and family members attending ≥13 sessions. Treatment retention was good with no premature drop-outs. Two of the 10 participant/family member groups, both including a patient, mother and father, attended all 16 sessions.

In terms of the acceptability of treatment, participants and family members rated R4R MFTG as suitable. At intake, suitability was rated positively by patients (mean 8.5 [1.7]) and family members (mean 8.3 [1.0]. Nine patients and 12 out of 13 family members rated suitability as ≥7. At discharge, the mean for patients was 8.1 (2.1) and family members was 8.2 (1.9). Similar to intake, 9 patients and 12 of 14 family members rated suitability as ≥7.

3.3 | Primary and secondary outcomes

Paired samples *t* tests and inspection of standardized effect size estimates (Cohen's *d*) were used to determine changes from BL to EOT and to 6MFU for BMI, EDE global score, LEA, and LAERS (see Table 2). Although BMI improved, change from BL to either EOT (0.16) or to 6MFU (0.22) indicate that these changes were modest. In contrast, the measures of ED psychopathology and emotion

regulation showed promising results with moderate to high effect sizes. Specifically, the EDE global score dropped from BL to EOT and continued this downward trajectory from EOT to the 6MFU. Effect sizes ranged from moderately strong (0.75) to very large (1.41). LEA and LAERS showed similar, but smaller, decreases from BL to EOT and BL to 6MFU. All effect sizes were in the moderate range (LEA: BL to EOT 0.49 and BL to 6MFU 0.47; LAERS: BL to 6MFU 0.57) with one exception. That is, change from BL to EOT in LAERS was smaller than the others (0.32). The data supporting study findings are available from the first author (M.T.) upon reasonable request.

4 | DISCUSSION

This study examined the feasibility and acceptability of R4R MFTG and established preliminary effect sizes for its impact on main and secondary outcome measures. In terms of feasibility, we recruited as planned and retained all 10 enrolled participants. Two friends (of patients) left group prematurely—one due to an elderly parent's illness and another because a participant no longer experienced one of her friends as supportive. In terms of acceptability, the majority of patients and families found R4R to be a suitable treatment.

Clinical outcomes were encouraging in that changes on all measures were in the expected direction. Changes in ED psychopathology were clinically and statistically significant from BL to EOT, as well as BL to 6MFU, providing preliminary support for R4R's ability to reduce AN symptoms during and after treatment.

R4R produced significant improvements in LEA, proving early support that it may help patients connect with their authentic feelings (Tantillo et al., 2015). Although changes on LAERS were not significant at EOT, these were significant at 6MFU, demonstrating patient improvements beyond EOT. These findings make intuitive sense, as changes in ability to monitor, evaluate, and modify emotional experiences take time (Lavender et al., 2015).

This study's findings also suggest that R4R promoted changes in ED psychopathology and emotion regulation, despite smaller gains in weight. Larger controlled studies are needed to explore if R4R's focus on repairing disconnections is able to leverage changes in AN symptoms in a fashion different from other treatments.

Although changes in weight were smaller throughout the study, these findings were in line with BMI improvements occurring regardless of outpatient therapy offered (Byrne et al., 2017). Additionally, R4R focuses more on emotional and relational processing skills than nutritional rehabilitation. Further research can examine whether solidifying these skills in recovery can contribute to future weight gain.

This pilot study demonstrated that R4R is a promising intervention for young adults with AN. However, our study was limited in terms of sample size, the lack of a comparison group, and broad inclusion criteria. We were unable to examine differences between participants receiving outpatient individual therapy and those in MFTG alone. Although we collected data on outside treatment at screening (sometimes several months before R4R began) and at 6MFU, we did not collect this information at BL or EOT. These data need to be collected in a future larger controlled study. We also broadened the inclusion criteria for young adults, as the literature supports later entry of individuals into "emerging adulthood" (Arnett, 2004; Wang & Parker, 2014). Additionally, individuals with AN can experience psychosocial challenges in adolescence that may extend into their 20s and 30s, potentially obstructing achievement of developmental milestones (Lowe et al., 2001). Future randomized controlled studies are required to evaluate R4R's treatment efficacy and usefulness for transitional age versus chronologically older adults.

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