CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

Project ECHO

ADVANCING INTEGRATED HEALTHCARE

Restrictive Eating Disorders ECHO®

Session 3: FBT

Date: November 16th, 2023

PLEASE NOTE: Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a project ECHO setting

Care Transformation Collaborative of RI

Welcome

- This session will be recorded for educational and quality improvement purposes
- Please do not provide any protected health information (PHI) during any ECHO session

Introduce Yourself

- Please turn on your video
- Please enter your name and organization in the chat box

Microphones

- Please mute your microphone when not speaking

Agenda

Time	Topic	Presenter
7:30 – 7:35 AM	**Welcome, Update**	Liz Cantor, PhD Christina Tortolani, PhD
7:35 AM – 8:25 AM	**FBT Basics**	Christina Tortolani, PhD
8:25 AM – 8:30 AM	**Q&A, Next Meeting**	Liz Cantor, PhD

Family Based Treatment: Pediatric Eating Disorders

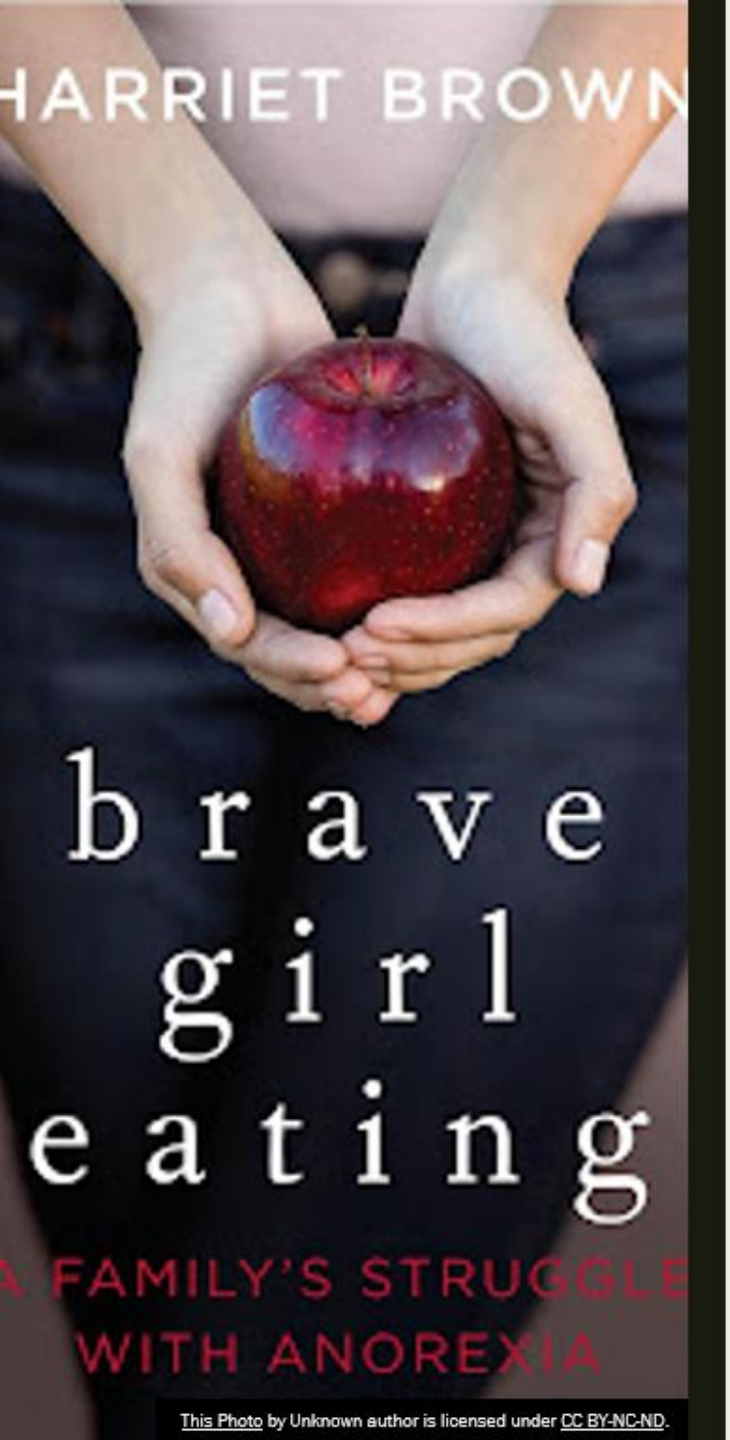
Christina Tortolani, PhD

Disclosures

- I have the following commercial relationship(s) to disclose:
  - Routledge, publication author; NIH, research funding

Learning Objectives

- Identify suitability, context and treatment style of family-based therapy (FBT), an evidence-based treatment for adolescents with eating disorders.
- Describe fundamental tenets of FBT
- Describe 1-2 FBT interventions to assist parents in taking charge of change in child's ED treatment.



Mindful Moment: *Brave Girl Eating*

- Parent perspective
  - *What I wish everyone knew…*
  - *I've never had anorexia, but I've lived with it*
  - *Before (my daughter) got sick, I thought eating disorders happened to other people's children.*
  - *No one chooses anorexia.*
  - *Know that you're not to blame, you're not alone, and you can make a difference in your child's life*

Caregiver Perspective

"How did I not catch this sooner?"

“Is this just a phase?”

“What do I do when he disappears after a meal and I know he is going to throw it up?

”Just how do we get her to eat again when she won’t let us”

“I don’t know what to do”

“I feel like I'm walking on eggshells"

“I don’t understand this illness; isn’t the solution straightforward- you eat and that’s that?”

“Am I to blame? I must have done something to cause the ED"

Adolescent with ED Perspective

"I don't have an eating disorder"

"I don't need help"

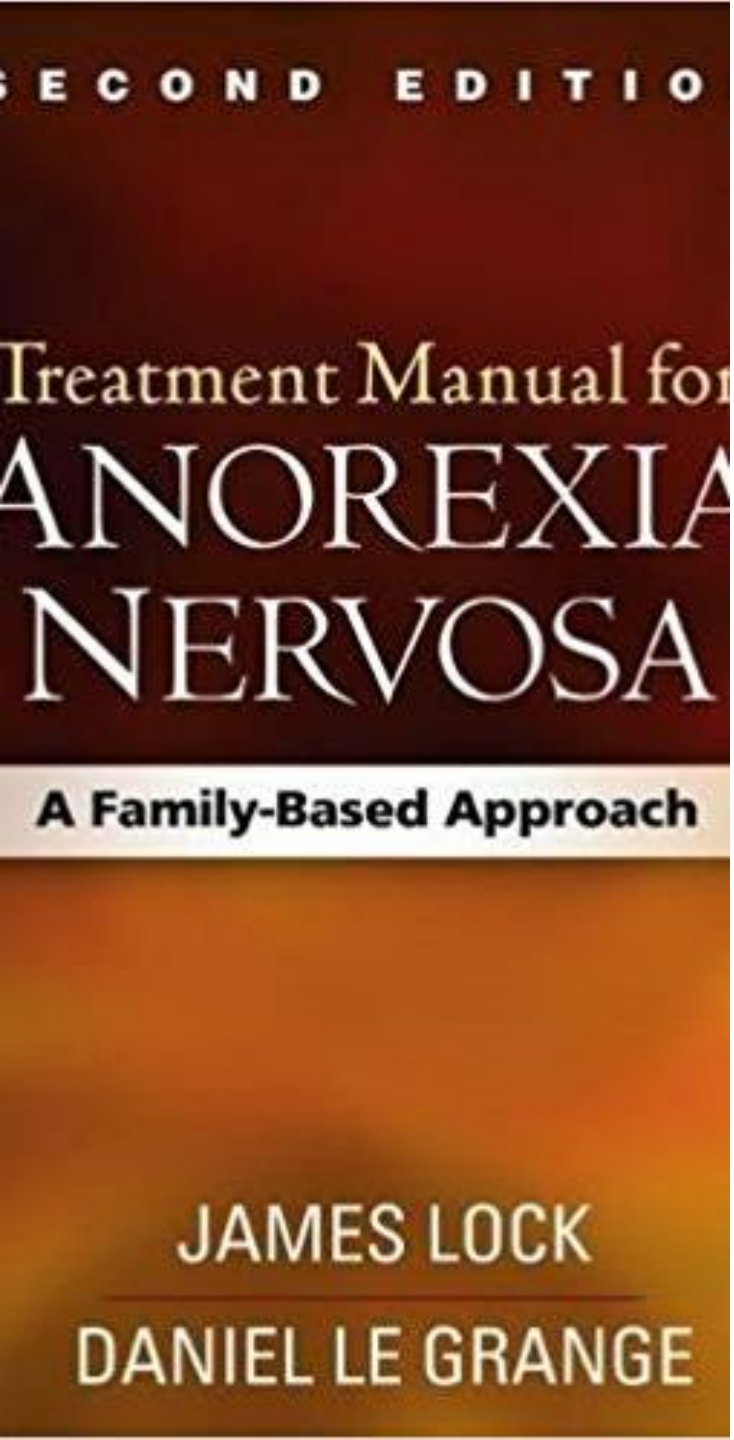
"I can take care of this myself"

"What's the big deal? All of my friends are dieting"

"Why are you punishing me? I hate you!"

"I hate going to therapy"

"I don't want to eat that. It's going to make me fat"



Family-Based Treatment for AN

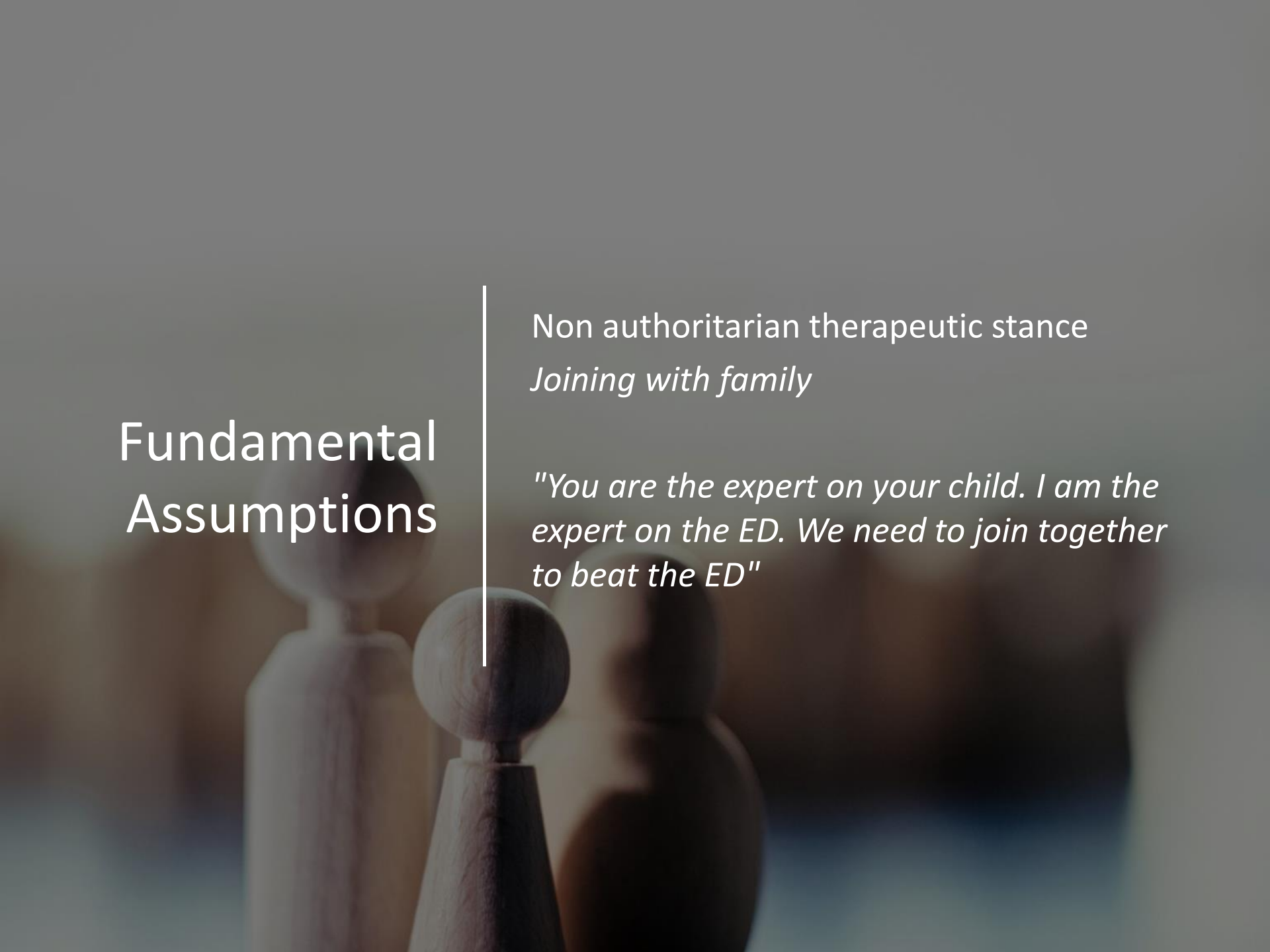
- Outpatient behavioral approach focused on weight restoration/ normalization of eating
- Delivered over 16 sessions in 3 phases
- Most well-established psychological treatment for adolescents to date
- Primary tenets:
  - Adolescent is not in control of behavior
  - Caregiver is vital to treatment success
  - Caregivers charged with refeeding starving child

Fundamental Assumptions

Agnostic view of cause of illness

- No one is blamed for causing or developing the disorder
- "The good news is that we do not need to know what caused it in order to fix it"

Adapted from “Helping parents help their kids: Understanding FBT,” by D. Le Grange

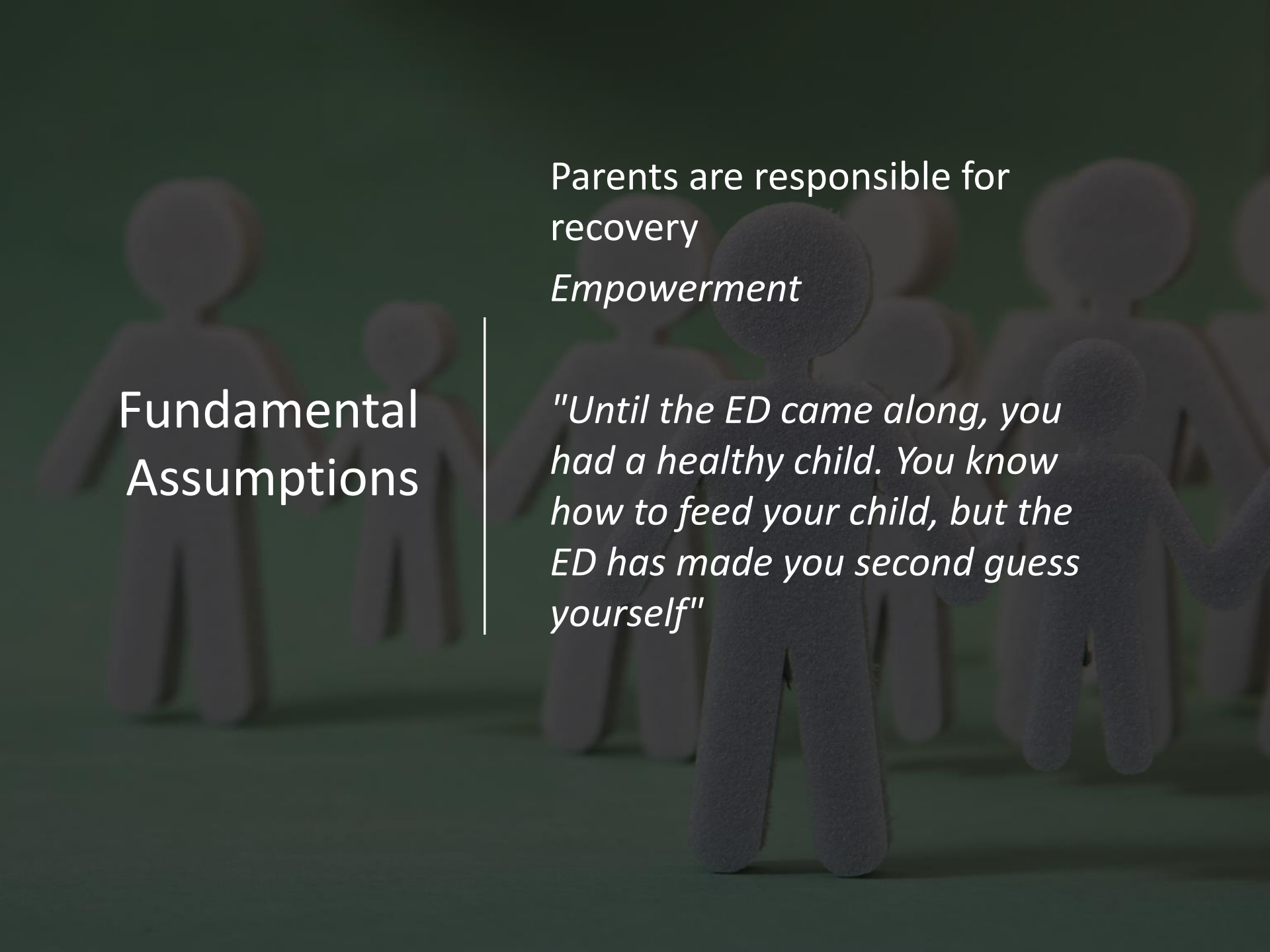


Fundamental Assumptions

Non authoritarian therapeutic stance

Joining with family

"You are the expert on your child. I am the expert on the ED. We need to join together to beat the ED"



Fundamental Assumptions

Parents are responsible for recovery

Empowerment

"Until the ED came along, you had a healthy child. You know how to feed your child, but the ED has made you second guess yourself"

Fundamental Assumptions

Externalization

Separation of child and illness

"Your child is in the grip of a powerful disorder that is influencing their thoughts, feelings and behaviors. Your child's brain has been hyjacked by the ED"

Fundamental Assumptions

Initial focus on symptoms

Pragmatic

"Laser like focused on BEHAVIOR and symptom reduction"

Suitability & Context

- Children and adolescents who are *medically stable* with eating disorders
- Outpatient intervention designed to restore weight AND put adolescent "back on track"
- FBT is a team approach
- Brief hospitalizations to resolve medical concerns

Treatment Style

Parents in charge	Appropriate control Agents of change together
Therapist Stance	Active- harness parents' anxiety Deference to parents
Adolescent Respect	Developmental process

RECOVERY VS. LIVING ALONGSIDE SYMPTOMS

Treatment Detail

Dose	Intensity	Format
• 6-12 months	• 10- 20 sessions	• Conjoint • Separated

Three Phases of FBT-AN

Phase I (Sessions 1-10)	• Parents in charge of weight restoration
Phase II (Sessions 11-16)	• Parents hand control over eating back to the adolescent
Phase III (Sessions 17-20)	• Discuss adolescent developmental issues

Le Grange et al., 2010

FBT Goals and Strategies

- Primary Goals
  - Educate caregivers about AN
  - Empower caregivers to refeed starving adolescent
  - Encourage siblings to support adolescent patient
- Key Strategies
  - Separate illness from patient
  - Modify caregiver criticism of patient
  - Weight patient
  - Observe in vivo family meal(s)
  - Support caregivers in refeeding
  - Align siblings with patient for support

Hypothesized Mechanisms

Exposure to forbidden foods and feared weight gains

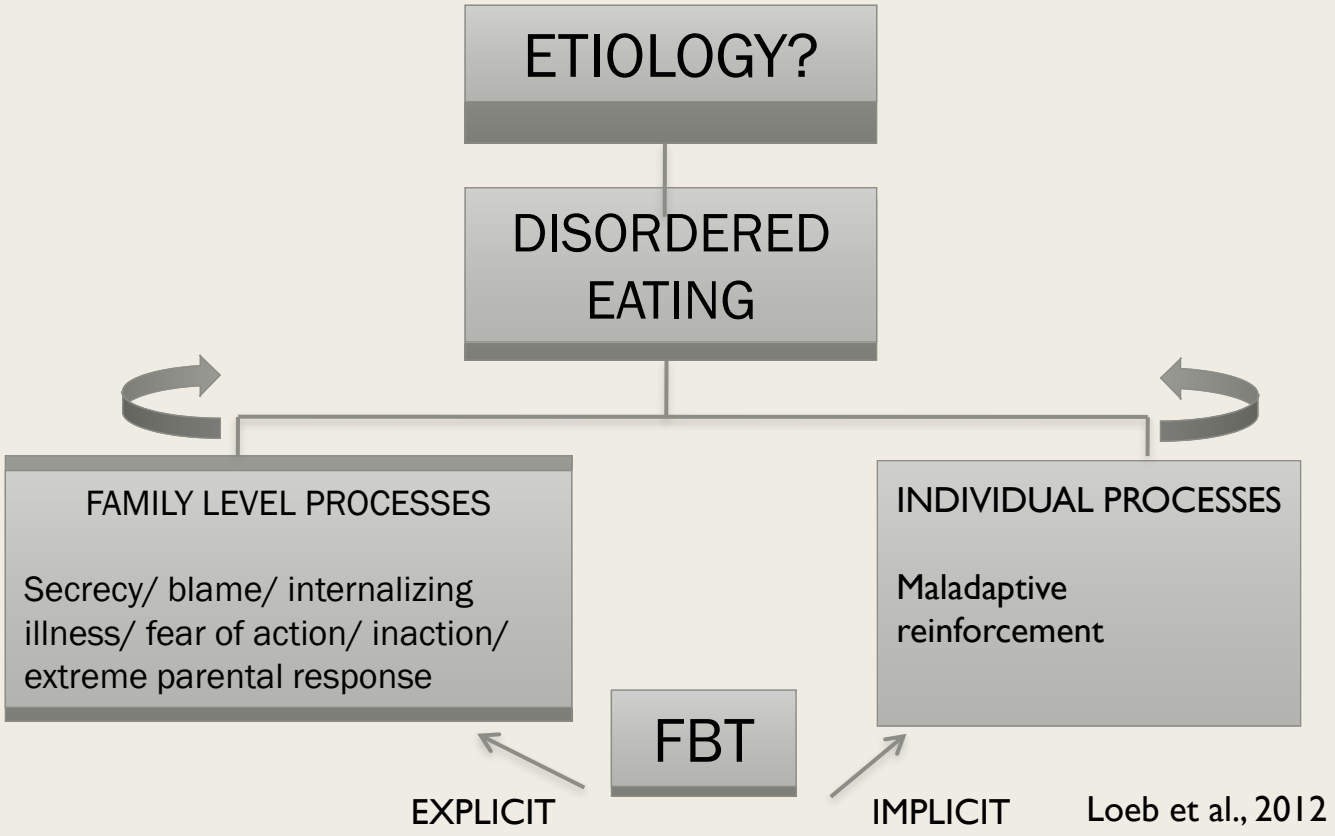
Restructuring of family authorities and coalitions

Hormonal regulation as a function of weight restoration

Training parents to identify warning signs and creating a long-term zero tolerance environment for symptom engagement

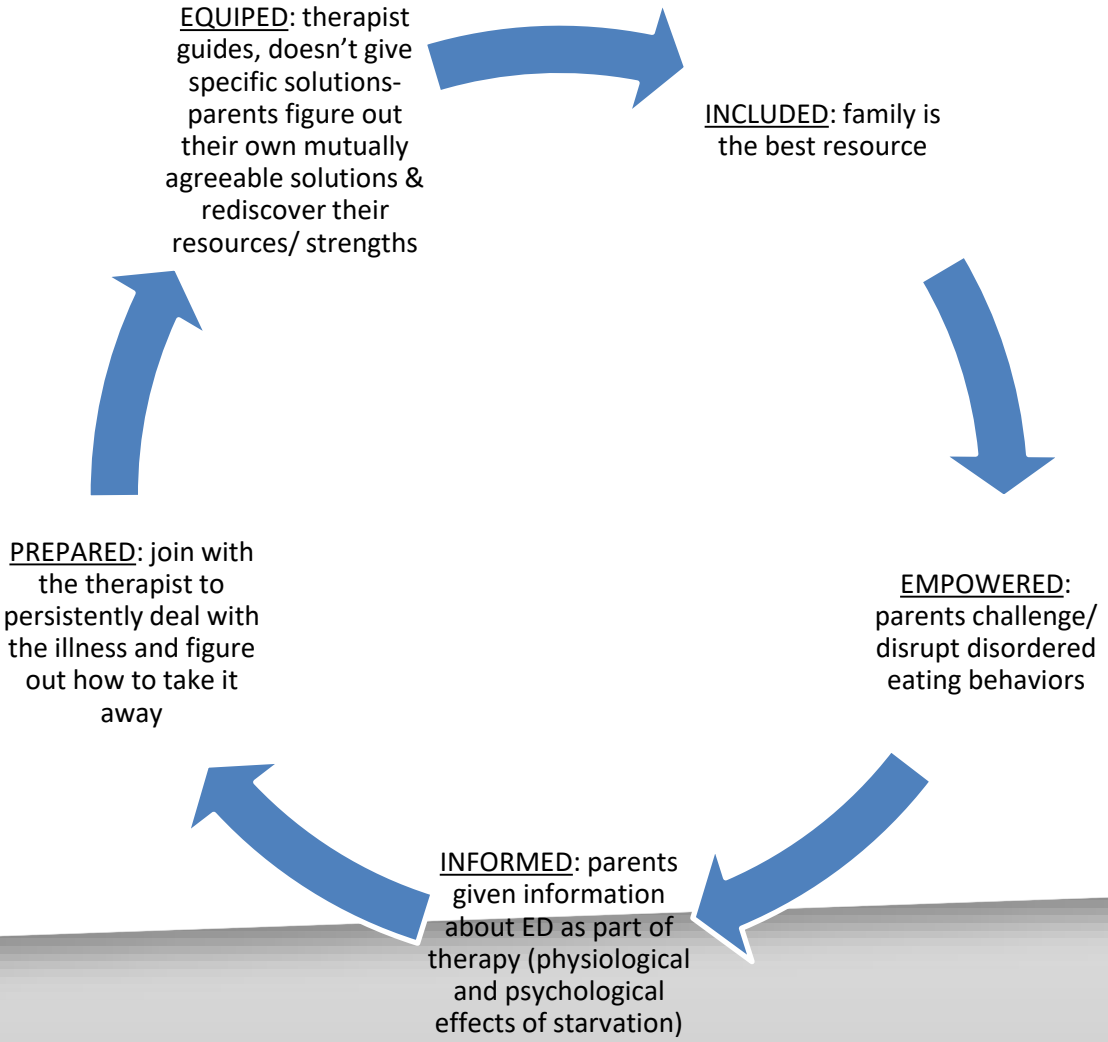
Le Grange et al., 2010

Transdiagnostic Model of FBT



Loeb et al., 2012

Parents are necessary



CASE: “Ryan”

- 15 yo male with recent onset of restrictive eating and excessive exercise (runner)
- Oldest of 2; intact family although marital strain
- Significant weight loss; hospitalized for medical instability
- Outpatient course of FBT conjoint

Overview of Phase I

Goals

- Helping parents take control of weight restoration processes- "hostage situation"
- Disrupt severe dieting, exercise and related dysfunctional behaviors that are leading to or maintaining low weight
- Progress monitored through weigh- ins

Le Grange et al., 2010

Phase I: *Empower Parents*

- *United* parental action
- *Set the tone*: this is a crisis
  - If AN persists, he could die. **This is "go" time. ACT NOW**
- Specifically *absolve* parents from blame for illness
  - Blame does not mean no responsibility
    - "You are not to blame for the problem, but **you can be part of the solution**."
  - Guilt reduces self-efficacy
    - "You can't parent well, choose treatment well or sleep well soaked in guilt."
- *Educate*: Know What You're Dealing With
  - Complexity of EDs (Facts vs Myths)
  - "You can't solve a problem until you know what you are dealing with"

Phase I: *Empower Parents*

- Circular questions to explore ED and impact on family > puts sxs in context
  - "What does your husband do when your son struggles to eat?"
- Who is the pt without an ED?
- How did family cope before ED?
- Help family focus on here and now…perspective of future orientation and expectation of change
  - YOU ARE IT! How would you feed your child if he were underweight for any other reason?

UNCOVER THEIR STREGNTHS TO DETANGLE FROM ED

Phase I: *Food as "medicine"*

- FOCUS on behavioral change: the aim is to return food & meals to their normal place
- Food is medicine: as in other illnesses, it is sometimes necessary to take unpleasant medicine
  - In order to recover, some med may have objectionable side effects or be difficult to take, but NEED TO do it.
- Food is FUEL… and eventually in context of role in culture (connection, celebration)
- "MAGIC PLATE"

Treasure, Smith & Crane, 2007.

REFEEDING IS NOT NORMAL EATING OR NORMAL PARENTING

“Ryan’s family”

- Target parents’ fear of inaction and symptom accommodation
  - The EDO becomes the elephant in the room
- ED thoughts= 90%
  - How might this be getting in his way of making food choices?
  - A starved brain cannot make rationale decisions
  - This is not about your son’s “will power”

PARENTAL ANGER= FAVORITE TOOL OF ED

PARENTAL FEAR= ED’S MOST POWERFUL TOOL

LEARN TO THINK LIKE ED

“Ryan’s Family”

- Parents are NOT on same page re: approach to re- feeding
- Mom colludes with ED by giving Ryan what he wants, not what he needs… due to denial about the development of ED…
- Dad takes a firm, practical approach- no nonsense
- Parents’ relationship strained and disconnected

"Ryan's family"

- How will your family do this?
  - WHERE/WHEN/WHO
  - Skills needed for meal coach: Calmness, compassion, consistency
  - Self-care strategies
- Make decisions *together*
  - For example, how will you … Monitor his exercise?
  - Does your son's current food intake represent "medicine" ???
    - Model healthy eating bxs- BROAD range of foods
    - SNICKERS vs. CARROTS

Treasure, Smith & Crane, 2007

“Ryan’s family”

- Come up with a plan:
  - Dad will do all food shopping and prep; food log of meals; rotate meals; 1 feared food/ week
  - Both parents will coach and do meal supervision
    - Play games
    - No debating with ED
    - Monitor movement
  - Sib will do after meal distractions

Weight Restoration=
“Brain Rescue”

Overview of Phase II

Guidelines for transition

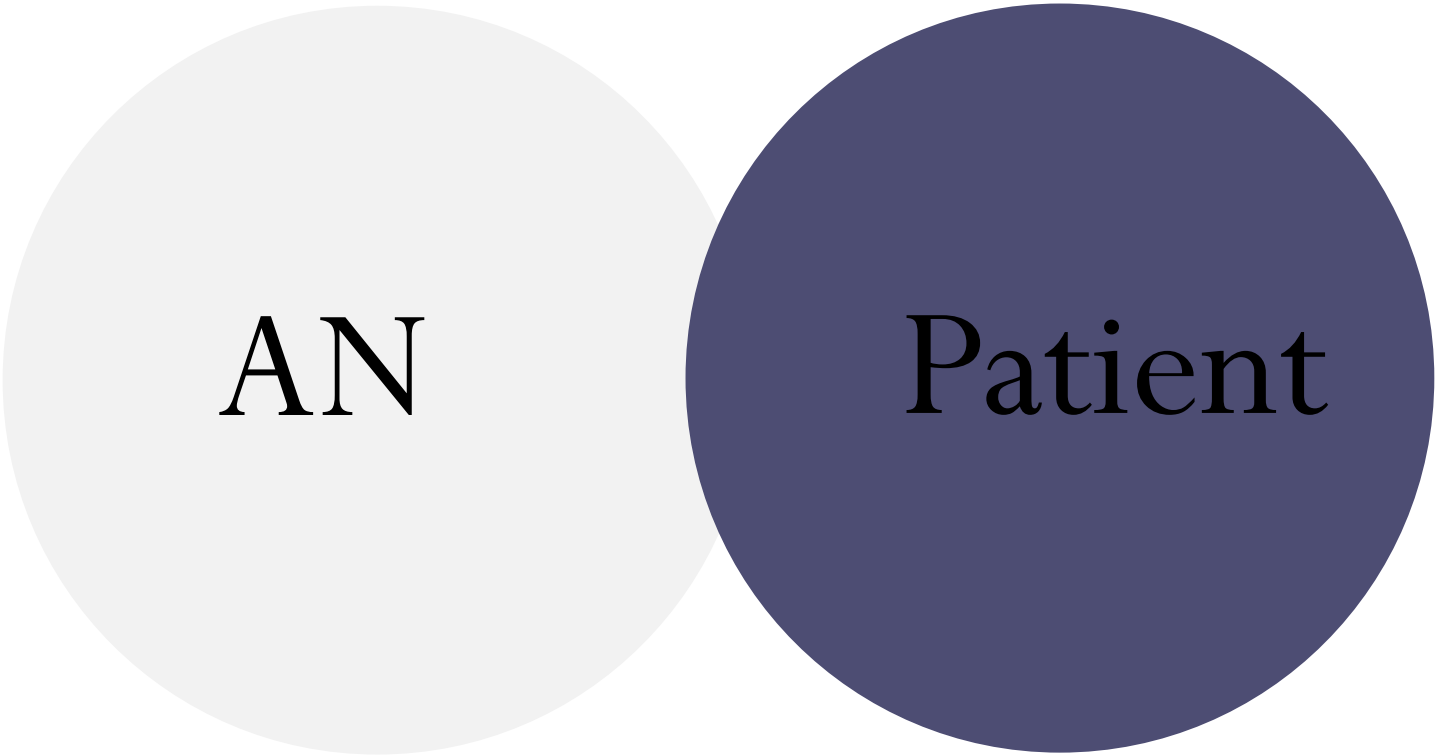
- Weight is at a minimum of ~90% EBW
- Pt eats without significant struggle
- Pt reports she feels empowered to manage illness

Goals

- Maintain parental management until pt can gain weight independently
- Transfer food/ weight control to adolescent- tailored to age of adolescent
- Explore developmental issues relative to AN

Le Grange et al., 2010

Phase 2: Adolescent is gaining control



Phase II:
Transition to Independent Eating

- Shift to teen eating in age appropriate way
- Continued weight tracking
- Gradual steps!
  - Don't change more than 1 variable
- Eating with others
- Restaurant scenarios
- Increased sibling involvement
- Parental response ranging from huge relief to terror

"Ryan's family"

TRIAL & ERROR
SAFE RISKS

- *"We see more of our Ryan every day. He's laughing again"*
  - ED thoughts are 30%; anxiety decreased with wt gain
  - Ryan admits he feels relieved… wants to get back to his life… *"I went out on Friday night!"*
- You have been working hard, you know how to stay 1 step ahead of EDO; at same time, there is good evidence that your daughter is making progress
- Let's talk about what this may look like…
  - Ryan will start with 1 snack/ day
  - Let's add some exercise… SLOWLY
    - *Spring track- modified*

Overview of Phase III

Guidelines for transition

- Weight is > 90% EBW
- Symptoms have dissipated, but some weight/ shape concerns may remain

Goals

- Revise parent- child relationship in accordance with remission of AN
- Review and problem- solve re: adolescent development
- Terminate treatment

Le Grange et al., 2010

Phase 3: Adolescent mastered sxs

Phase III: Normal Adolescence

- Psychological distress, dependence on parents, missed school, social isolation have derailed normal development
- Psychoeducation: puberty, identity development, intimacy, vocational paths; athleticism
- Identifying both teen and parent concerns
- Struggle to differentiate teen behavior from AN behavior
- Termination: themes of safety and uncertainty

"Recovery"

- A *full* recovery profile vs. alleviation of 1 symptom
  - ED thoughts
  - Body systems
  - Growth curve
  - Rather than target weight, where does body find its set point?

Recovery is not a matter of IF, but HOW

“Ryan’s family”

- Weight restored
- Conversations no longer focused on food
- Dealing with “stress”
- Started driving!
- Exercise to feel good/ be part of a team
- Re-engage in healthy peer relationships
- Balance of parents’ optimism about weight gain with staying focused on recovery- oriented lifestyle

FBT Take Home Lessons

- No one is to blame for an eating disorder
- The eating disorder is separate from patient (even though it doesn’t often seem like it)
- Parents are your best tool in re-feeding
- Food is medicine

CME Credits

(applied for MDs, PAs, Rx, RNs, NPs, PhD)

- BH clinicians can submit their certification to their accrediting agency for credit equivalency
- CME Credits – Please request session credits when filling out the evaluation at the end of the meeting.
- Evaluation/Credit Request Form: https://www.surveymonkey.com/r/RSKN6W9
- Evaluations must be completed to receive credit
- Certificates will be mailed ~ 1 month after event

Thank you!

Next Meeting:

Thursday December 21st, 2023 - 7:30 – 8:30 AM

Food is Medicine

Evaluation/Credit Request Form: https://www.surveymonkey.com/r/RSKN6W9