ADVANCING INTEGRATED HEALTHCARE

Restrictive Eating Disorders ECHO®

Session 4: Food is Medicine

Date: December 21st, 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

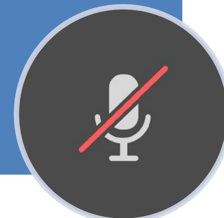
- This session will be recorded for educational and quality improvement purposes
- Please do not provide any protected health information (PHI) during any ECHO session

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, Updates, & Case Presentation Schedule**	Liz Cantor, PhD
7:35 AM – 8:25 AM	**Food is Medicine**	Christina Tortolani, PhD
8:25 AM – 8:30 AM	**Q&A, Next Meeting**	Liz Cantor, PhD

Case Presentation Schedule

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND | pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Session Title	Date	Presenter
Session 5: Externalizing the illness	January 18th, 2024	Heather Pelletier, East Greenwich Pediatrics
Session 6: Family Meal/Meal Coaching	February 15th, 2024	Brittany Vose, Aquidneck Pediatrics
Session 7: Partnering with Caregivers	March 21st, 2024	**OPEN**
Session 8: Collaborative Weighing	April 18th, 2024	**OPEN**
Session 9: One Team, One Message	May 16th, 2024	**OPEN**
Session 10: Harnessing Parental Anxiety	June 20th, 2024	**OPEN**
Session 11: Navigating Challenging Family Dynamics	July 18th, 2024	**OPEN**
Session 12: Brain Recovery – Success Stories	August 15th, 2024	Heather Pelletier & Brittany Vose

Family Based Treatment:

Case Illustration
"Food is Medicine"
Brain Recovery

Christina Tortolani, PhD

Disclosures

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

Learning Objectives

- Identify 1-2 FBT interventions as illustrated through a clinical case presentation.
- Recognize the rationale for "food is medicine" approach
- Describe "brain recovery" in pediatric patients with EDs.

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?

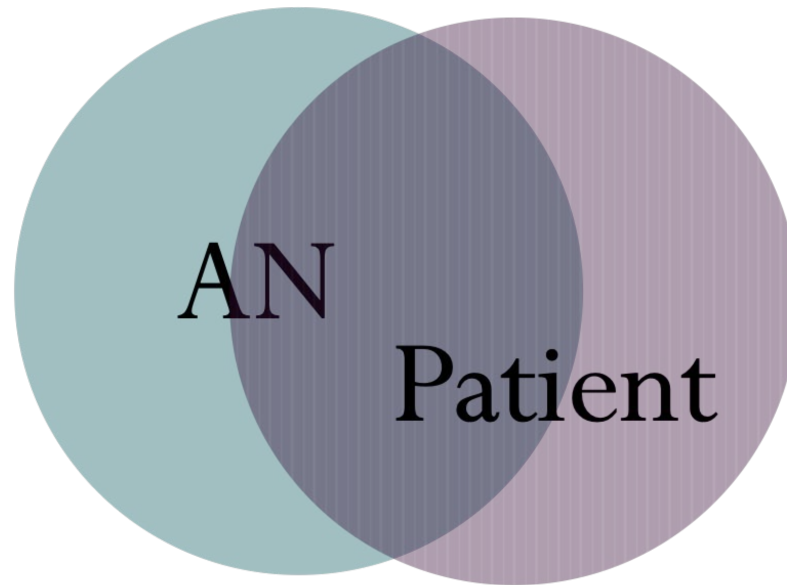
How did family cope before ED?

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

How an ED overshadows True Self



Where did my child go???

The ED Rules

"The greater the belief that you are stronger, smarter and have more staying power than ED; the greater the chance your child will come to believe that too."

"By helping her gain weight, WE ARE WAGING WAR AGAINST THE EDO, not my child"

"Our child did not voluntarily choose to have an EDO"

"…the same way if she/ he had cancer, we would not think she/ he actively chose to be sick"

"No one is at fault for an EDO, including us."

"Our job as parents is to set clear limits on the EDO and let her/ him know we are there for her and believe in her recovery"

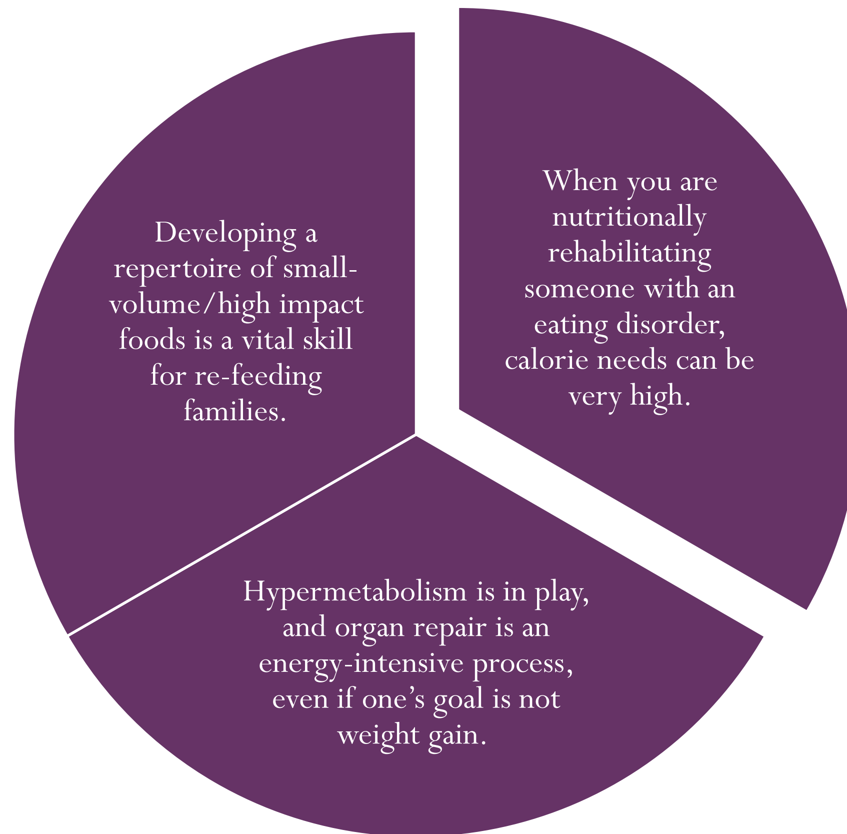
"ED creates an unrelenting, daily, moment to moment conflict for her, as if her loyalties are divided between the EDO and her well being"

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"
- Resources

Treasure, Smith & Crane, 2007.

"Big Impact, Small Footprint"



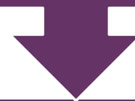
The Body's Response to Inadequate Fuel

Jaimie Winkler, RD, LDN and David Alperovitz, Psy.D.

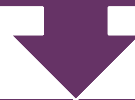
- Energy reallocation (energy gets alloacted from less impt processes/ structures to the most impt ones)
  - THINK: bear in hibernation
- Increased Interest/ the "pull" toward food (whenever you avoid food, you are more drawn to it- this is distinct from enjoyment of food)
  - THINK: food obssesionality without actually eating
- Energy Insufficiency (suppresses all emotions- pos/ neg)
  - THINK: restriction's function= "numb out"

The role of the RD in FBT

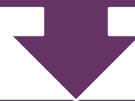
Typically, FBT calls for a therapist to guide the parents and a medical doctor to manage medical needs. A dietitian, although not required, is extremely useful in helping to educate both parents and kids to make the refeeding experience as pleasant as possible.



Not all parents have a unbiased nutrition knowledge, nor are they able to find an appropriate meal plan for their child's weight restoration or health management.



The dietitian's role in FBT is to help the family develop a meal plan that meets the patient's nutritional needs while addressing their individual preferences and challenges. The dietitian will determine a target weight range goal by viewing growth charts, considering their puberty stage, and calculating projected height goals. The dietitian can also educate and support the family about the importance of proper nutrition and its role in the recovery process.



https://www.feast-ed.org/fbt-informed-nutrition-counseling-for-dietitians/

FBT INFORMED NUTRITION COUNSELING FOR DIETITIANS

- Among the key shifts dietitians pivoting to FBT will need to understand are the following:
  - The dietitian does not need to meet with teen
  - The dietitian works with the parents to empower them to develop the meal plan and to feed
  - Much higher-calorie meal plans are possible and needed DBT skills can be helpful for dysregulation
  - Distraction is far more useful than mindfulness
  - Within the course of FBT, Intuitive Eating is not necessarily the goal

REFEEDING IS NOT NORMAL EATING OR NORMAL PARENTING

"Ryan's family"

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"

Target parents' fear of inaction and symptom accommodation

- The EDO becomes the elephant in the room

PARENTAL ANGER= FAVORITE TOOL OF ED

PARENTAL FEAR= ED'S MOST POWERFUL TOOL

LEARN TO THINK LIKE ED

What? You want me to eat a meal in front of you? Huh? Why?

- What does it look like?
- What is a "*magic plate*"?
- WHY is *food my child's "medicine*"?
- What "*dose*" of medicine does my child need?

- GOALS: Help our children RELEARN how to:
  - Eat enough- sufficiently for the body's needs
  - Eat flexibly <u>and</u> with variety
  - Eat socially- with food set in the context of the bigger picture of life

BY DISOBEYING THEIR ED

REFEEDING IS *NOT* NORMAL EATING
OR
NORMAL PARENTING

"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 he 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

Patient

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!”*

“We are scared to let go of control"

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

“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

"What constitutes Recovery?"

- A *full* recovery profile vs. alleviation of 1 symptom
  - ED thoughts/ fear of eating (Cognitive)
  - Body systems/ Growth curve (Physiological)
  - Normalized eating/exercise (Behavioral)

Recovery is not a matter of IF, but HOW

"Brain Recovery:"

Neurobiological restoration

Eating disorders cause physical and functional changes in the brain. Various brain scans, such as CAT scans, PET scans, and fMRI scans, have found:[1]

- Loss of brain mass
- Loss of brain anatomy
- Changes in brain chemistry
- Changes in brain blood flow
- Changes in neuro-hormones

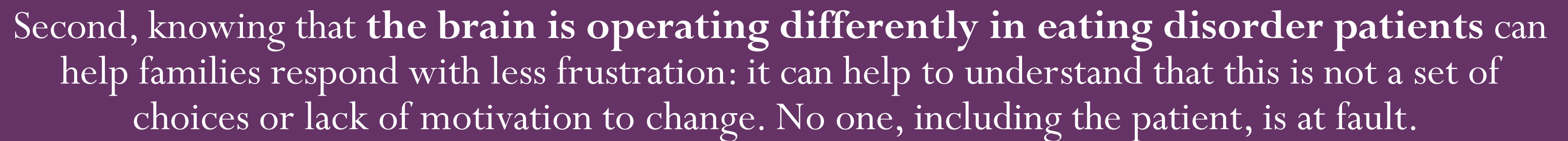
From a neurobiological perspective, full recovery can't happen until these brain deficiencies and losses have been rectified, and functioning and structure has been restored.

- For example, if someone has an extreme drive to lose weight, even if they gain weight, they need to change that drive, which has changed the brain.
- "Rewire"

1. Esther Walton, Fabio Bernardoni, Victoria-Luise Batury, Klaas Bahnsen, Sara Larivière, Giovanni Abbate-Daga, et al. (2022)

F.E.A.S.T.'s Message re: Neuroscience

The most important lesson from neuroscience is that **eating disorders are treatable**.



Second, knowing that **the brain is operating differently in eating disorder patients** can help families respond with less frustration: it can help to understand that this is not a set of choices or lack of motivation to change. No one, including the patient, is at fault.

Finally, parents and **families need to focus on helping the patient regain their health through normal eating**, providing a warm and supportive family environment, and working with a clinical team with the most recent training and expertise.

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
- FBT= Weight restoration= Brain Recovery

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

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Thank you!

Next Meeting:

Thursday January 18th, 2024 - 7:30 – 8:30 AM

Externalizing the Illness

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