CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

Project ECHO®

ADVANCING INTEGRATED HEALTHCARE

# Restrictive Eating Disorders ECHO®

## Session 11: Navigating Challenging Family Dynamics

Date: July 18th, 2024

*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

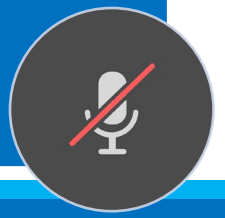
- This session will be recorded for educational and quality improvement purposes
- Please do not provide any protected health information (PHI) during any ECHO session

**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 – 7:55 AM | **Family-based treatment of patients with eating disorders: Family systems challenges and opportunities in primary care** | Michelle Rickerby, MD |
| 7:55 – 8:10 AM | **Case Presentation** | Michelle Beller, MD |
| 8:10-8:25 AM | **Case Presentation** | Laura Beaudry, LICSW |
| 8:25 AM – 8:30 AM | **Wrap Up, Next Meeting** | Christina Tortolani, PhD<br>Liz Cantor, PhD |

# Case Presentation Schedule

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| Session Title | Date | Presenter |
|---|---|---|
| Session 12:<br>Brain Recovery – Success Stories | August 15th, 2024 | Heather Pelletier &<br>Brittany Vose |

# FAMILY-BASED TREATMENT OF PATIENTS WITH EATING DISORDERS: FAMILY SYSTEMS CHALLENGES AND OPPORTUNITIES IN PRIMARY CARE

MICHELLE RICKERBY MD

CTC-RI

7/18/2024

# FAMILY SYSTEMS CHALLENGES AND OPPORTUNITIES: OBJECTIVES

1

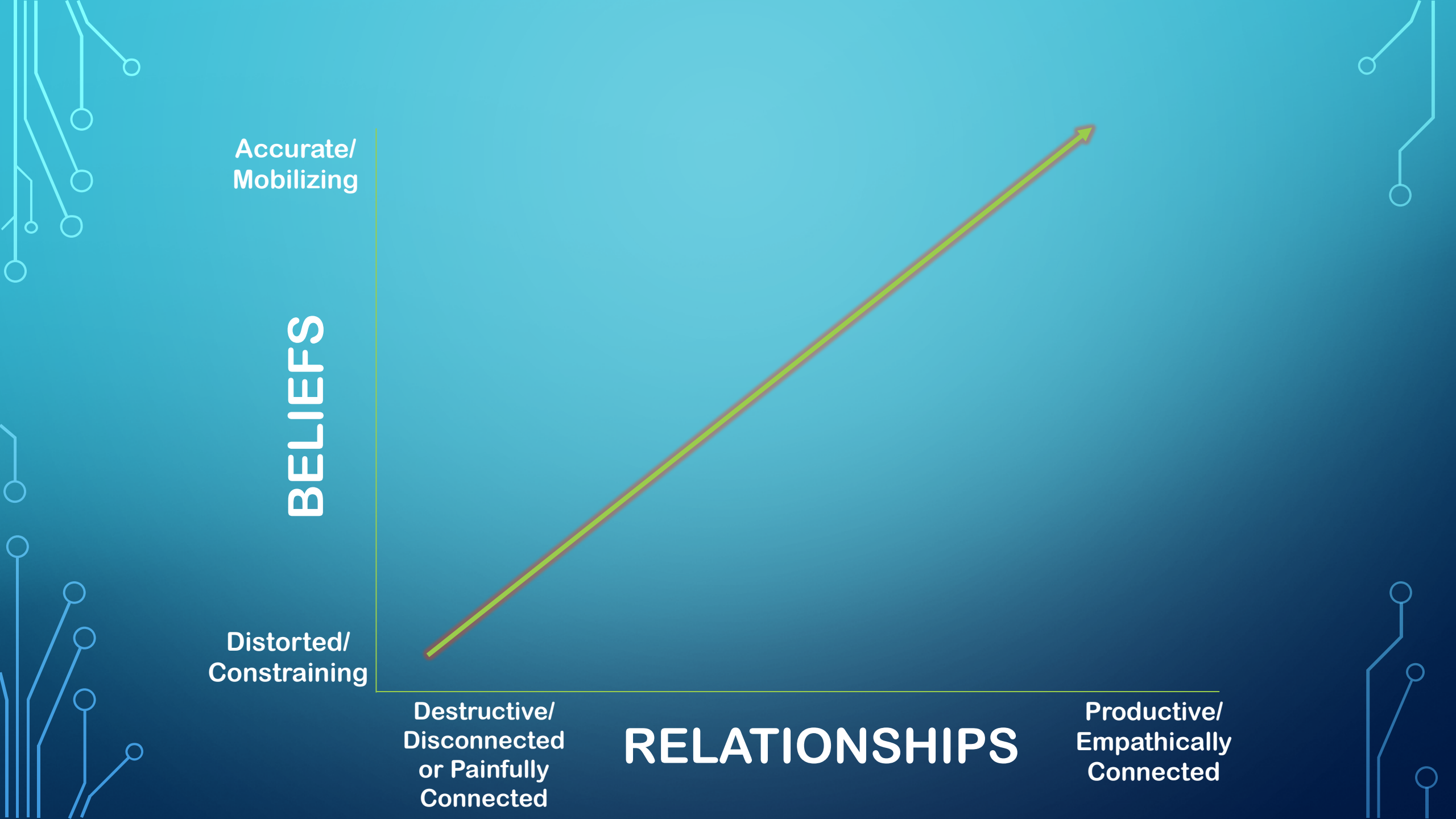
Participants will become familiar with common family systems belief challenges in the context of treating children and teens with eating disorders.

2

Participants will become familiar with common family systems relationship challenges in the context of treating children and teens with eating disorders.

3

Participants will learn about some tools to support productive conversations in the context of these family systems challenges in treating patients with eating disorders.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# SUPPORTING PRODUCTIVE CONVERSATIONS

The importance of knowing when to stop talking to the eating disorder

Offering frameworks that support an accurate understanding and also guide the family how to communicate productively rather than destructively

The power of magnification of messages across providers

# COMMON ”BELIEF CHALLENGES” IN TREATING PATIENTS WITH EATING DISORDERS

- Level of acceptance<>denial of the presence of the eating disorder
- Level of understanding of the degree of impact of the ED on thoughts and behavior
- Acknowledging both the medical and psychological aspects of recovery
- Understanding how to ”Externalize” the eating disorder
- Ackowledging the impact of the ED on Relationships

# BELIEFS: LEVEL OF ACCEPTANCE<>DENIAL OF THE PRESENCE OF THE EATING DISORDER

- **It is very unusual to meet a patient living with an eating disorder who is 100% committed to recovery.**
- **Patient and family members may be in different places with this and it may vary day to day.**
- Productive questions/Frames:
  - ”Is there any part of you that wants to fight this ED?”
  - “I know you believe this is you and not an ED. I will continue to be honest with you about how the eating disorder is affecting you as we go about what I think will help you be medically and psychologically healthy.”
  - “Who in the family is having the hardest time understanding the ED and who understands most?”

# BELIEFS: LEVEL OF UNDERSTANDING OF THE DEGREE OF IMPACT OF THE ED ON THOUGHTS AND BEHAVIOR

- **Patients will often minimize their reporting of this.**
  - **Acknowledging it makes it real**
  - **They are fearful of more restrictions if they are honest**
- Going through the checklists of the range of symptoms is helpful to reinforce awareness.
- **It is often hardest for parents to understand the cognitive symptoms.**
- Productive Questions/Frames
  - "EDs will often push you to not be honest about what you are going through. The more honest you can be the more I can help."
  - "When your Mom/Dad sees you doing a better job eating do they understand how hard it is for you? What do you wish they could understand?'

# BELIEFS: APPRECIATING BOTH THE MEDICAL AND PSYCHOLOGICAL ASPECTS OF RECOVERY

- **It is common for parents to be so relieved about successful weight restoration/medical stabilization that they can lose sight of ongoing severe ED psychological challenges.**
- It is crucial to reinforce the connection between the two.
- Steps in progression towards independence can't be skipped!
- Productive Questions/Frames
  - 'It's often once things medically stabilize that the even harder work begins psychologically…"
  - "Food is medicine and will help the psychological recovery process but progress medically will also lead to your daughter/son's distress ramping up more because of the psychological power of the ED."

# BELIEFS: UNDERSTANDING HOW TO "EXTERNALIZE" THE EATING DISORDER

- **Kids and teens often struggle early in recovery to differentiate their thoughts and actions from ED thoughts and actions.**
- **Externalizing the ED helps take pressure off family relationships.**
- Productive Questions/Frames
  - "The goal is for you become part of the team with all of us and your parents to fight your ED and the control it has over your life, not for you as a person to feel ganged up on."
  - "Mom/Dad you may need to remind him/her that you are not angry at her but rather you are so mad at the pain the ED is causing him/her. "

# BELIEFS: APPRECIATING THE IMPACT OF THE EATING DISORDER ON RELATIONSHIPS

- **It is normal that living with an eating disorder is very isolating.**
- **It is normal that living with an eating disorder puts a lot of strain and pressure on friend and family relationships.**
- Productive Questions/Frames
  - "I understand that your ED is making it hard for your to feel connected to your friends and family in a normal way. What is hardest for you about this?"
  - "I know that right now it feels like you are living with an ED not with your daughter/son. She/he is in a trap with this and our working together to give black and white messages will help with them get out of the trap."
  - "Some families feel like the ED can really pull them together and some like it blows them apart and most feel that both happen, what is it like for you/your family?"

# COMMON RELATIONSHIP CHALLENGES

- Parent-Child
  - The patient perceives parent/s' efforts are "against them" rather than a means of "fighting the eating disorder"
  - Parental accommodation of ED versus "no negotiating"
  - "This is not my child"
  - Pre-existing relationship challenges are magnified
- Parent-Parent
  - Parental splits
  - Division of labor
  - Parental burn out

# RELATIONSHIPS: PATIENT PERCEIVES PARENT/S AS FIGHTING THEM RATHER THAN THE ED

- **The importance of "externalizing the eating disorder"**
- These dynamics can become very complex if there is a parent split going on.
- Productive Questions/Frames
  - "Mom/Dad is it sometimes hard for you to tell when you are arguing with the ED versus with your son/daughter?"
  - "What helps you most from your parents when the ED is really loud and strong?"

# RELATIONSHIPS: PARENTAL ACCOMMODATION OF ED VERSUS "NO NEGOTIATING"

- **EDs are very manipulative to patient and family.**
- **If patients don't appear to exhibit any distress as the meal plan plays out we are missing something.**
- **Especially early on in weight restoration parents are so relieved that "he/she is eating more" that they often get pulled into a lot of bargaining which serves to strengthen the ED.**
- **Productive Questions/Frames**
  - "What is the best and worst part for you about moving forward with your meal plan?"
  - "Any decisions that are based on input from the eating disorder are not healthy for your child."

# RELATIONSHIPS: "THIS IS NOT MY CHILD"

- **It is very common for patients to lie or hide aspects of what is going on when in the throes of an eating disorder.**
- Levels of agitation (emotionally and behaviorally) that have never been seen before in the patient are common
  - Suicidal ideations, self injury, elopement, disparaging comments to family
- Productive Questions/Frames
  - "I understand that you are an honest person but that sometimes the ED pushes you to lie to me or your parents. What is hardest for you about that?"
  - "When it feels really out of control it's a reminder of how strong the ED is. The calmer you can be at those times the more it will help your child/teen."
  - If "backing down" happens there needs to be a clear message at the time and after.

# RELATIONSHIPS: PRE-EXISTING RELATIONSHIP CHALLENGES ARE MAGNIFIED

- Pre-existing distant or high conflict relationships
- Parents psychological, developmental or psychiatric challenges
  - Level of parent insight about these challenges is highly variable
- Productive Questions/Frames
  - "What is hardest for you about parenting your child through this?"
  - **"Does the fact that you have lived with an eating disorder (or that you lived with someone else in the family with an ED) make it harder, easier or both for you to support your child with this?"**

# RELATIONSHIPS: PARENT SPLITS

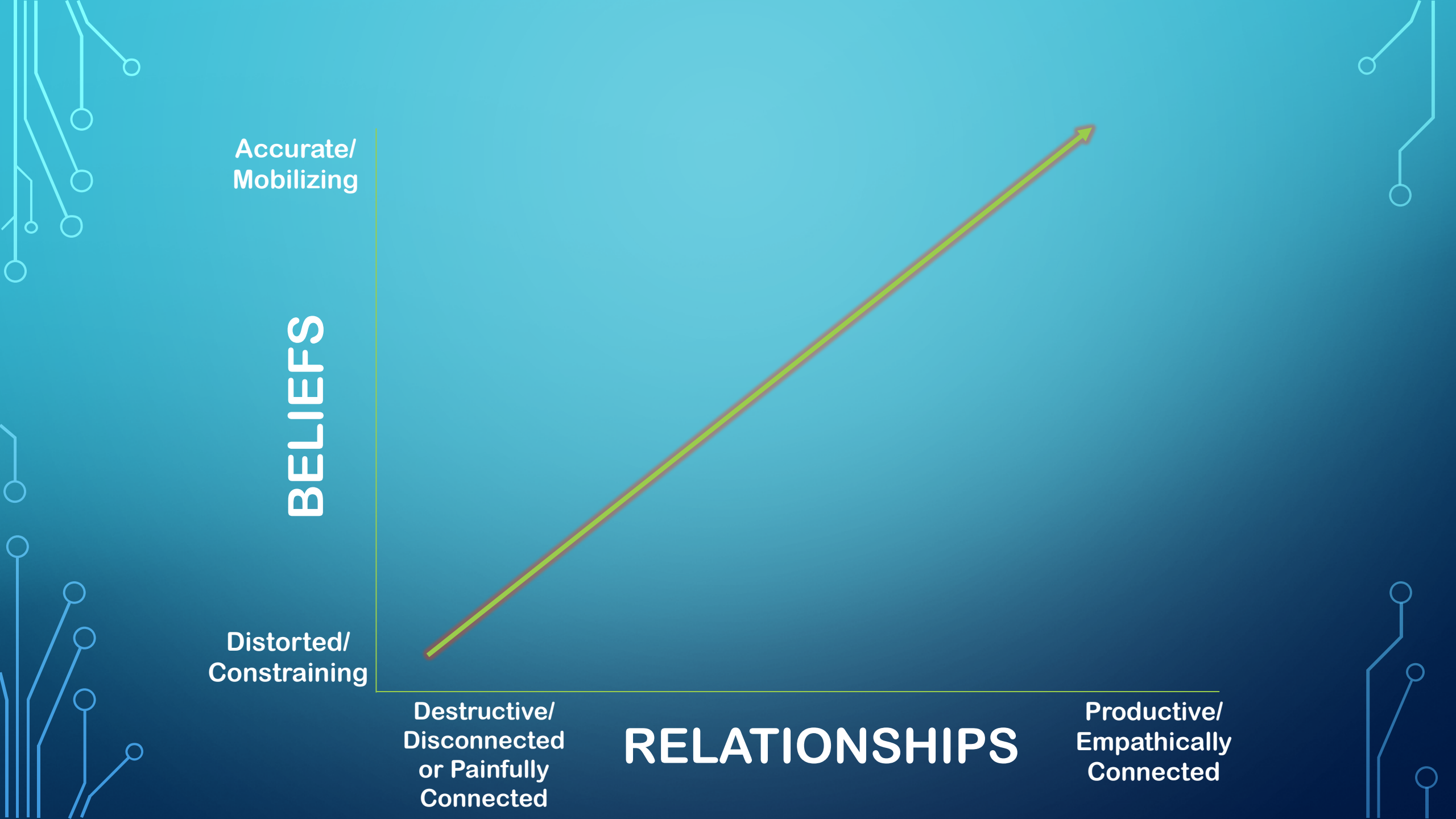
- It is a very common phenomenon that even parents who are parenting under one roof have very different personalities and/or parenting styles.
- **JOINED AND ACCURATE MESSAGES FROM PARENTS ARE THE MOST IMPORTANT PART IN RECOVERY.**
- **The longer mixed messages/splits persist the harder the ED will be to treat.**
- Productive Questions/Frames:
  - "Would your son/daughter say you mostly agree or disagree about how to support them managing their eating disorder (or in general)?"
  - "If you are trying to make a decision and are not sure you are together in it, or that you are together with the treatment team, it's better to put off the decision than make it and give a mixed message."

# RELATIONSHIPS: DIVISION OF LABOR

- In families there is a huge range of how labor is divided.
- **Not everyone has to be good at everything when it comes to managing an eating disorder (different roles are okay as long as messages are not undermined).**
- **If it's a situation that there is a clear "front line parent" we need to be careful of not boxing out the other parent or of setting up front line for burn out.**
- Productive Questions/Frames
  - "What is the hardest/easiest part for Mom/Dad/grandma… managing this plan?"
  - "How can Dad/Mom best back you up supporting him/her at meal time?"
  - "Even though Mom/Dad is usually the one taking you to all of your appointments what is most important for Dad/Mom to know about the plan?"

# RELATIONSHIPS: BURN OUT

- **Supporting families in Family-Based Treatment of an Eating Disorder is like asking them to run a marathon and not know how long it is.**
- The risk of this is always there but higher with parental psychological/psychiatric challenges and in high conflict marriage and/or divorce.
- Families perceived as most "high functioning" often don't get enough psychological support early on in the process of treatment.
- Productive Questions/Frames
  - "I know you won't be able to take a breath until he/she is more stable but if you can't breathe it may make it harder for you to be there for your child. So, I'm going to remind you to breathe and make sure you have the help you need."
  - "Some families say this process pulls them together and others that it pulls them apart and many say it's both. What is it like for your family?"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# TAKE HOME LESSONS:
## THE "GOOD NEWS" REGARDING HIGH INTENSITY ILLNESS CHALLENGES

- Illness beliefs and interpersonal relationships within families can, in fact, be modified, and targeting these areas does improve outcomes.
- If we "know where we are" with family relationships and illness beliefs, we know what to do.
- Consistent messages matter and are powerful.
- Excellent provider collaboration is a strong force in supporting patient/family success.
- Any painful challenge/symptom/illness is improved with an empowered set of beliefs about illness and empathic relationships, which is most effectively accomplished via family-based treatment in the context of integrated messages from providers.

# APPLICATIONS TO YOUR PRACTICE

**Be aware of the power of messages to patients and families**

Keep it simple

- Externalizing the illness
- Normalize strain for individuals and on relationships

Comment on the larger picture even if you are responsible for a small part of care

**Consider how your practice group team can improve both internal communication as well as that with other providers across the system of care**

ADVANCING INTEGRATED HEALTHCARE

# Restrictive Eating Disorders ECHO®
# Case Presentation

Presenter(s): Michelle Beller, MD, Barrington Peds

Date: **July 18, 2024**

Contact Info:

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*Care Transformation Collaborative of RI*

# Basic Patient Information

Do Not Include PHI

| | |
|---|---|
| Age/Grade | **14 yo / going into 9th grade** |
| Gender Identity | **female** |
| Race/Ethnicity | **Hispanic** |
| Current Weight and Height | **Weight: 112.8 lb. Height: 61.25 in** |
| BMI percentile and expected body weight | **67% / 132 lb.** |
| Family constellation | **Lives with Mom, Stepdad, Grandmother, younger half brother. Has family in Guatemala.** |
| How long has this individual been in your care? | **since 2018** |
| Insurance type (Commercial, Medicaid, Uninsured, Other) | **NHP RiteCare** |

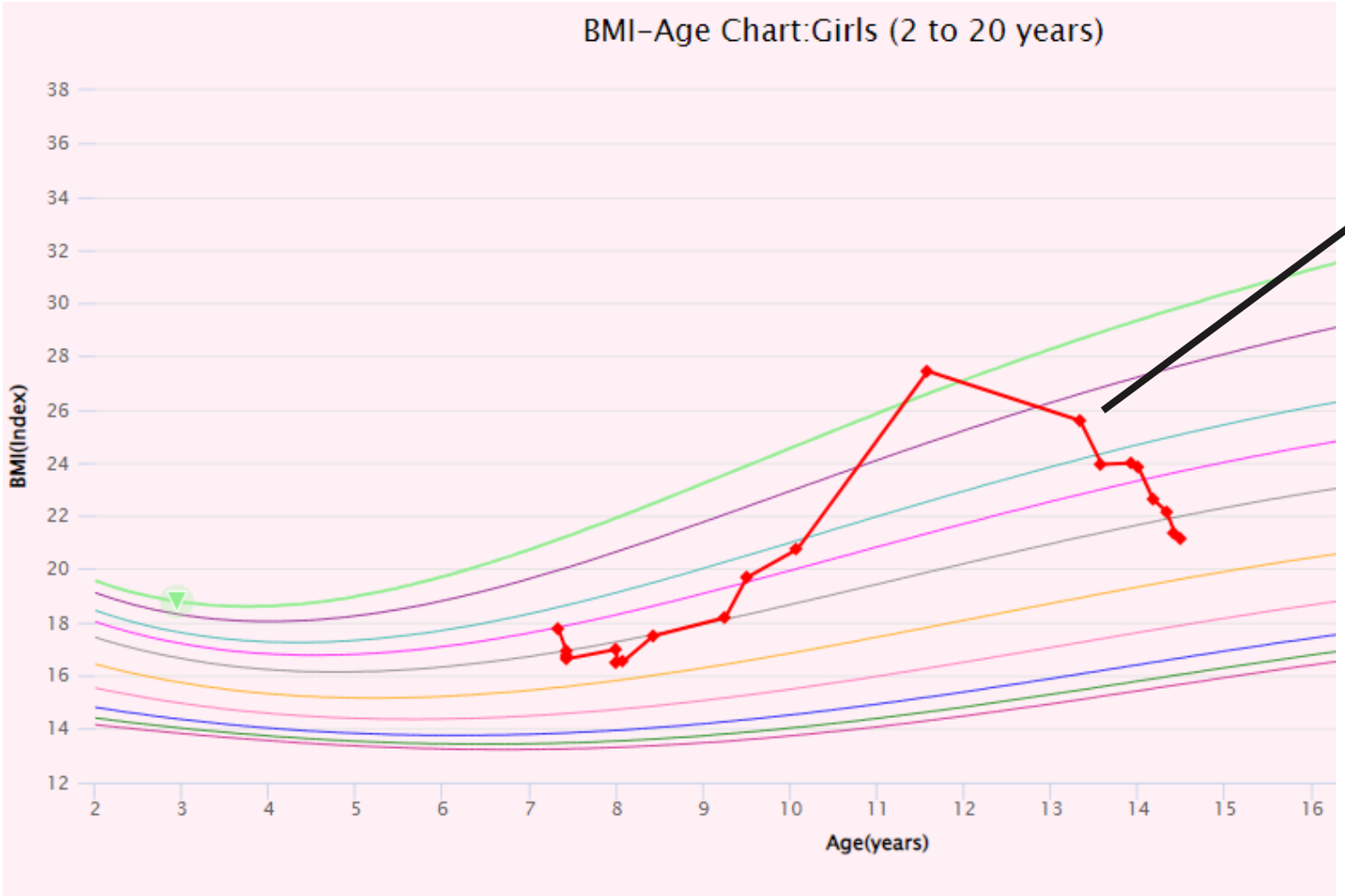
# Reasons for Selecting this Case

Do Not Include PHI

| | |
|---|---|
| Presenting Problem | - Routine visit 4/2023 – Stepdad was concerned for some restriction; patient reported low appetite WITHOUT intentional restriction<br><br>- Follow up visit 10/2023, patient endorsed intentional restriction/desire to lose weight - which she says was not initially the cause of her weight loss |
| What questions do you have for the group? | 1. When to start treating as an eating disorder (initially no weight loss, denied intentional restriction)?<br>2. How to decide when to refer to Adolescent Eating Disorder clinic?<br>3. Recommendations for eating disorder specific nutritionists that accept state insurance? |

# Growth Curve

Do Not Include PHI



# Relevant Background & Social History

Do Not Include PHI

| | |
|---|---|
| Relevant medical and/or behavioral comorbidities | **Since development of eating disorder, intermittently reporting depressed mood and passive SI** |
| Relevant medications/lab results | **labs normal 12/2023** |
| Family stressors? | **Parents work a lot; has step siblings that visit that are treated differently** |
| School related concerns? | none |

# Eating Disorder Treatment History

Do Not Include PHI

| | |
|---|---|
| What interventions have been tried (e.g. re-feeding, meal supervision, exercise restriction) | **Project Home (in home FBT), transitioned to outpatient FBT through the Providence Center.**<br>**Just had intake with Adolescent Medicine.**<br>**Restricted from spring volleyball.**<br>**Referred to Hasbro PHP.** |
| What treatment barriers have the family identified? | **Family typically has their dinner early** |
| Other? | **Family has missed several visits.**<br>**Step-Dad initially identified the issue but seems less engaged at this point. Mom seems to have a hard time being consistent with offering increased nutrition** |

# Physical Activity

Do Not Include PHI

| | |
|---|---|
| Does the patient engage in regular physical activity? (yes/no)<br>Please describe | **No. Played volleyball previous years but restricted this year. Pt did not want to play when she learned that it would mean she would have to eat more to compensate.** |

# Patient /Family Successes and Strengths?

Do Not Include PHI

Mom and step-dad both supportive, want to help
Step-dad initially identified the concern
They have engaged in some treatment recommendations

# Summary & Clarifying Questions

# Reasons for Selecting this Case

Do Not Include PHI

| | |
|---|---|
| Presenting Problem | - Routine visit 4/2023 – Stepdad was concerned for some restriction; patient reported low appetite WITHOUT intentional restriction<br><br>- Follow up visit 10/2023, patient endorsed intentional restriction/desire to lose weight - which she says was not initially the cause of her weight loss |
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ADVANCING INTEGRATED HEALTHCARE

# Restrictive Eating Disorders ECHO®
# Case Presentation

Presenter(s): Laura Beaudry, LICSW

Date: **July 18, 2024**

Contact Info: lbeaudry2@lifespan.org

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*Care Transformation Collaborative of RI*

# Basic Patient Information

Do Not Include PHI

| | |
|---|---|
| Age/Grade | **16** |
| Gender Identity | **Male** |
| Race/Ethnicity | **Caucasian** |
| Current Weight and Height | **Weight: 109 Height: 5'7** |
| BMI percentile and expected body weight | **17.1 – underweight** |
| Family constellation | **Mom, dad, 12 yo sister** |
| How long has this individual been in your care? | **5 weeks** |
| Insurance type (Commercial, Medicaid, Uninsured, Other) | **Medicaid** |

# Reasons for Selecting this Case

Do Not Include PHI

| | |
|---|---|
| Presenting Problem | *At 14 year WCV, Mo shared with the pediatrician that patient had been **excessively exercising and "eating clean"** (no carbs or very little carbs), eats mostly protein and vegetables<br>***Calorie counting** (e.g. when mother cooking meals, patient will remark about every ingredient including spices. He worries that the spices are "needless calories")<br>***Little insight** into his disordered eating and behavior, **no desire to change**.<br>***Frequent activity to burn calories or build muscle** (run in place, do squats, do pull ups) |
| What questions do you have for the group? | How to motivate patient to take an interest in his own treatment. He will attend appointments without much participation.<br><br>Put treatment on hold? |

# Weight for Age

Do Not Include PHI

| Date | Weight (lbs) | %ile |
|---|---|---|
| March 2023 | 114.6 | 39.49 |
| June 2023 | 110.4 | 26.79 |
| December 2023 | 110.4 | 18.33 |
| January 2024 | 109 | |
| March 2024 | 109 | |
| June 2024 | 109 | |

# Relevant Background & Social History

Do Not Include PHI

| | |
|---|---|
| Relevant medical and/or behavioral comorbidities | none |
| Family stressors? | **Significant family stressors**<br><br>**Mother recently diagnosed with FMD**. This illness has been debilitating. Mom has needed to stop work. She must lay down often, has daily migraines without much relief, dizzy spells, nausea.<br><br>**Father has had to take over all adult responsibilities for his household and for his own father**, who had double lung transplant for long term pulmonary fibrosis. Patient's father is stopping at the house daily to help with daily chores and meals. Father **sees a therapist** weekly and admits to be **"at my breaking point."** |

# Eating Disorder Treatment History

Do Not Include PHI

| | |
|---|---|
| What interventions have been tried (e.g. re-feeding, meal supervision, exercise restriction) | **Exercise restriction** – he is most angry about this. He can be found doing pull ups from the open beams in his house. He will engage in movement constantly to "burn calories and increase muscle." He used to go to gym 5 days a week for 2.5 hours. Mostly lifting weights and would run for 20 minutes with a "plastic" outfit so he would sweat more.<br><br>**Meal supervision** – Father is responsible for meal monitoring. He is exhausted by this time of day and wants to relax at dinner time. |
| What treatment barriers have the family identified? | Very **difficult to monitor exercise** bec of mother's illness and father being "maxed out"<br>**Patient's attitude** about "fat" people |
| Other? | **Patient often mean and taunts his 12 year old sister who is overweight;** triggering to Laura, frustrating to family. |

# Patient /Family Successes and Strengths?

Do Not Include PHI

- Agreed to intake
- Both parents have their own therapist and buy in to mental health treatment
- Patient willing to attend sessions
- Mother is very present on the days her illness allows

# Summary & Clarifying Questions

# Reasons for Selecting this Case

Do Not Include PHI

| | |
|---|---|
| Presenting Problem | *At 14 year WCV, Mo shared with the pediatrician that patient had been **excessively exercising and "eating clean"** (no carbs or very little carbs), eats mostly protein and vegetables<br>***Calorie counting** (e.g. when mother cooking meals, patient will remark about every ingredient including spices. He worries that the spices are "needless calories")<br>***Little insight** into his disordered eating and behavior, **no desire to change**.<br>***Frequent activity to burn calories or build muscle** (run in place, do squats, do pull ups) |
| What questions do you have for the group? | **How to motivate patient** to take an interest in his own treatment? He will attend appointments without much participation.<br><br>Put treatment on hold? |

# 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 August 15th, 2024 - 7:30 – 8:30 AM

Brain Recovery – Success Stories

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