Key Interventions in Family-Based Treatment for Eating Disorders

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Presentation Outline

- Eating Disorders in Children and Adolescents
- Risk Factors
- Early onset Eating Disorders & Medical Risks
- Family Based Treatment Overview
- Key Interventions
- Case Studies

Eating Disorders in Adolescents

- Anorexia Nervosa is the 3rd most common chronic illness of adolescence
- Bulimia Nervosa affects more than 1% of adolescent girls
- Also, many do not fulfill criteria, but do have sub-threshold (ED NOS)

Risk Factors

- Predictors of AN: female sex, early feeding or undereating problems, maternal depressive symptoms
- Predictor of EDs (all catagories): being perceived as overweight by a parent
- Protective factors: higher BMI, higher self esteem

Herzog and Eddy, JAACP 2009, 48:8 782-783

APA Practice Guidelines

- To avert potentially irreversible effects on the CNS, physical growth and development, many children and adolescents require inpatient treatment
- Inpatient treatment: Wt <85% of individually estimated healthy wt, rapid or persistent decline in oral intake or weight, medical or psychiatric instability
- Emphasis on family based treatment interventions

Psychiatric Comorbidities

- Mood and anxiety disorders most common
- High levels predict more severe ED
- Approximately 80% with AN and BN are diagnosed with another disorder at some point
- Anxiety disorders often precede onset of ED in children
- OCD symptoms in up to half of children and adolescents but obsessive-compulsive personality traits less frequent and not typically diagnosed in children

CHARACTERISTICS OF EOED

- Age
  - Onset less than age 14
  - Typical onset between 14-18*
- Gender
  - More boys than in typical AN*
  - 25% boys in EOED (usual 10% male)
    - London group 13/48 children male**
    - Australian population study 25/101 were boys***
- Pre pubertal

* DSM IV TR
** Arch Dis Child, 1987
***Med J Austral, 2009

COMPLICATIONS

- Volume loss of the brain
- Growth retardation
- Delayed puberty
- Osteopenia/osteoporosis

Family Based Therapy

- Historically, parents were less involved and were encouraged not to be the "food police"
- There is no research to support that such an approach is effective in achieving recovery.
- Family based therapy (FBT) was introduced in the mid-1980's
- Previously known as the "Maudsley Method."

Family Based Therapy

- FBT is an Outpatient Treatment Protocol
- FBT focuses on mobilizing parents as a primary resource in treating children and adolescents with EDs.
- All family members are viewed as a resource and asked to participate in the treatment.
- While taking an agnostic view (parents are not to blame) about causes, emphasis is placed on the seriousness of the illness including the physical risks to organ systems including the bones, heart, and brain
- ED is viewed as interrupting normal adolescent development.
- Separation of the child and the illness

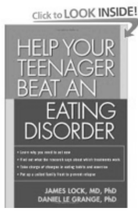
Family Based Therapy

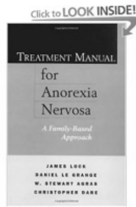
- 10-20 sessions over 6-12 months; 3 phases of treatment
- Conjoint vs Separated
- Family Based Therapy is the most studied and supported treatment for adolescent AN, effective for adolescent BN
- Therapeutic Stance: Therapist serves as an expert consultant-most decisions are left to the parents

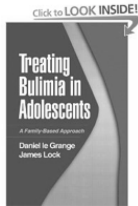
Family Based Therapy

- Treatment manuals for AN and BN by Lock, Le Grange, et al.
- Treatment is divided into 3 phases and typically occurs over a period of 6-12 months.
  - Phase 1 (Sessions 1-10)
    - Parents restore their child's weight
  - Phase 2 (sessions 11-16)
    - Transfer control of eating back to the adolescent
  - Phase 3 (Sessions 17-20)
    - Address adolescent development issues

FBT Resources







Prior to starting the Treatment Protocol

- Assessments are completed to ensure the patient is medically stable for outpatient treatment
- Diagnostic interviews with the patient and family are completed
- Parents are stable candidates to help (live with the patient, no abuse, not substance dependent or psychotic)
- Education about bringing the entire family for treatment

Phase 1

- Focus is on Re-feeding the patient, monitoring of meals, and weight restoration.
- Entire family included.
- Emphasis is on behavioral change.
- Help the parents to take charge of the patient's eating.
- Reduce parental blame.
- Mobilize sibling support.

Key Interventions in Phase I

- Treatment Alliance
- Parental Alliance
- Sibling Alliance
- Collaborative Weighing
- Family Meal
- Problem Solving
- Persistance

First Session

- Establish treatment alliance (bonding, setting goals, and taking steps to achieve goals)
- Medical model and mobilize support
- Collaborative weighing

Key Intervention: Collaborative Weighing

- Keep the family focused on the ED
- Start of each session includes weighing the patient and plotting it on a weight graph collaboratively with the patient and family
- Exposure therapy

Second Session-The Family Meal

- Family meal: goal is to continue the assessment and to help coach the parents.
- Assess family process during meals.
- Provides an opportunity for the parents to successfully feed the patient.

Remainder of Phase I

- Maintain alliances
- Reduce expressed emotion (criticism, hostility, emotional over-involvement)
- Phase 1 complete when patient has restored to>87.5%, and there is a decrease in struggles between parent and child.

Problem-Solving

- Big problem-getting stuck in Phase I
- Orientation to problems
- Problem-solving strategies, including options and steps of problem-solving
- Persistence
- Empowering parents to find solutions

Phase II

- Focused on helping the child to eat on his/her own.
- Patient eats without significant struggle
- Slowly return control of eating back to the adolescent with continued parental oversight.
- Start to explore developmental issues
- Phase 2 complete once the child has restored 90-100% of ideal body weight and is able to eat regular meals without supervision.
- Sessions scheduled every 2-3 weeks. 2-6 sessions.

Phase III

- Phase 3 starts when patient is 90-100% ideal body weight and responsibility for eating has been returned to the patient.
- Focused on adolescent issues and termination of treatment.
- Sessions become less frequent (every 4-6 weeks, 3-4 sessions).
- Review normal adolescent development and ensure that the patient is back on a normal track in these domains.
- Model Problem solving skills
- Family boundaries, increasing autonomy for the adolescent

Phase III cont.

- Discuss relapse and relapse prevention
- Encourage fear of relapse
- Help patient and family to establish a relapse prevention plan.

Challenges of Implementing FBT

- Non-intact families
- Previous treatment experiences
- Psychiatric co-morbidities
- Expressed emotion (criticism, hostility, emotional over-involvement)
- Coordination of care
- Maintaining the treatment alliance

Case #1

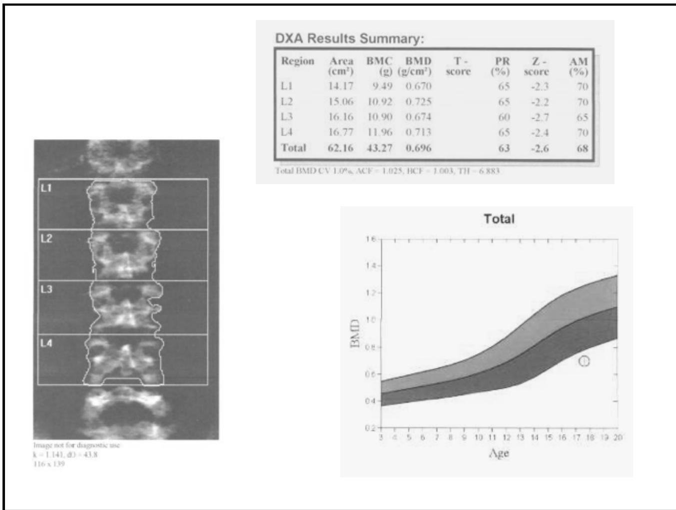
- MF is a 17 yo cross country state champion
- Losing weight in outpatient treatment
- Admitted with medical instability including BMI of 16, HR in high 20s, hypothermia, volume loss of the brain on MRI
- Initially refusing to eat or drink, NG tube place
- Depression with Self Injurious Behaviors
- Treated with fluoxetine to 80mg daily, aripiprazole up to 12mg (quickly tapered) and hydroxyzine 30-40mg qid

Case #1 cont.

- Family based treatment protocol implemented
- Family meal, collaborative weighing, pros and cons of change
- NG tube removed at BMI 19
- Continued restoring weight to goal BMI 21.5 (established from growth chart)

MRI IMAGE

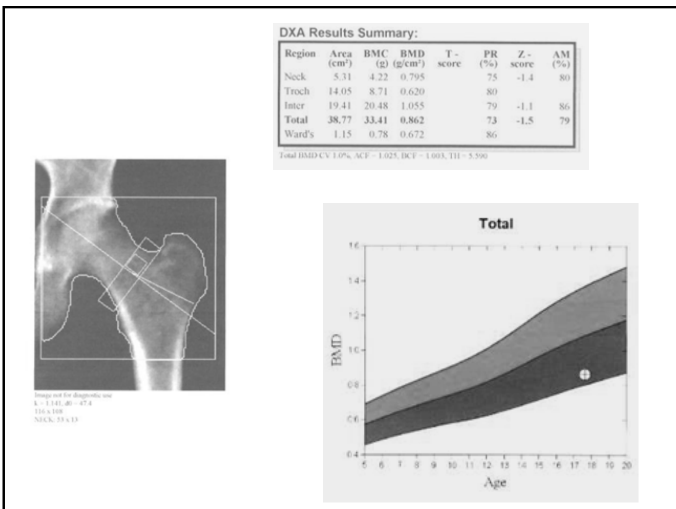
- 11/11/10 MRI Brain – Mild borderline cerebral and cerebellar volume loss



DXA Results Summary:

Region	Area (cm^2)	BMC (g)	BMD (g/cm^2)	T - score	PR (%)	Z - score	AM (%)
L1	14.17	9.49	0.670		65	-2.3	70
L2	15.06	10.92	0.725		65	-2.2	70
L3	16.16	10.90	0.674		60	-2.7	65
L4	16.77	11.96	0.713		65	-2.4	70
Total	**62.16**	**43.27**	**0.696**		**63**	**-2.6**	**68**

Total BMD CV 1.0%, ACF = 1.025, BCF = 1.003, TH = 6.883



DXA Results Summary:

Region	Area (cm^2)	BMC (g)	BMD (g/cm^2)	T - score	PR (%)	Z - score	AM (%)
Neck	5.31	4.22	0.795		75	-1.4	80
Troch	14.05	8.71	0.620		80		
Inter	19.41	20.48	1.055		79	-1.1	86
Total	**38.77**	**33.41**	**0.862**		**73**	**-1.5**	**79**
Ward's	1.15	0.78	0.672		86		

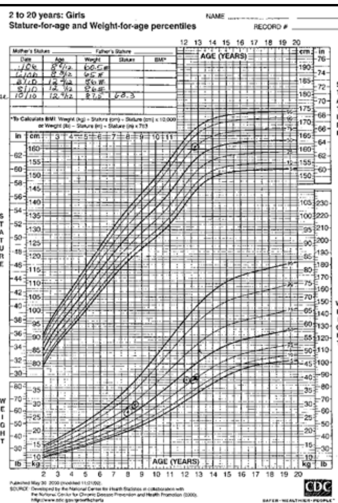
Total BMD CV 1.0%, ACF = 1.025, BCF = 1.003, TH = 5.590

CASE # 2

- DM is a 12 yo female athlete
- Weight loss, hospitalized with bradycardia and BMI of 15.5
- Developed depression with self injurious behavior (cutting)
- Treated with fluoxetine 60-80mg, brief trial of aripiprazole, and hydroxyzine 20mg qid
- Refusing to eat or drink, NG tube feeding
- Family Based Treatment

CASE #2 CONT.

- Collaborative Weighing
- Multi-Family Group for Girls Age 11-13 with Active Problem Solving, Emotion Regulation Strategies, and Cognitive Behavioral Interventions Targeted at Self Esteem



Contingency Management

- Goal: to help parents provide an adaptive balance of direction and emotion
- Avoid high levels of expressed emotion (criticism, hostility, and emotional over involvement)
- 2 helpful resources
  - "Skills-based Learning for Caring for a Loved One with and Eating Disorder" by Janet Treasure
  - "Don't Shoot the Dog!" by Karen Pryor

Conclusions

- Find a balance between flexible responsiveness and adherence to treatment guides
- Consider the importance is training and case consultation and supervision in dissemination of evidence-based therapies
- Examples from Coping Cats and DBT

Using CBT-E with Adolescents

- May be useful for patients 15-18
- No research on it's use with patients under age 18
- If adolescent's weight is within 20% IBW, CBT-E may be appropriate
- If the degree of weight loss is greater than 20% IBW, CBT-E should follow a preliminary intervention
  - Family Based Treatment
  - Inpatient or Day Treatment

CBT-E with Adolescents

- Parents are involved from the outset
- Education about the nature of eating disorders and what treatment involves
- Adolescent would be encouraged to share their formulation with parents
- Regular joint sessions with the patient, therapist and parent to keep them informed and to discuss how they can facilitate the adolescent's efforts to change eating behaviors.
- Parents can help them eat at regular intervals, introduce avoided foods, and address aspects of body checking (remove bathroom scales, excessive mirrors, etc)

CBT-E with Adolescents

- Younger patients may need more guidance about what they need to eat than adults, parents may also need to be included in these discussions.
- When discussing pros/cons of change, may need to focus particularly more on the immediate future and those factors that are more likely to motivate adolescents

What is DBT?

- Behavioral treatment approach originally designed to treat adult patients with chronic suicidality and self-injury.
- 4 modes of treatment are utilized concurrently:
  - Weekly skills training group
  - Weekly Individual therapy sessions
  - Telephone coaching/consultation
  - Weekly consultation group for providers
- 9 Randomized Control Trials support its effectiveness in the treatment of BPD.

Why use DBT with Eating Disorders?

- Research shows that CBT and IPT only are effective in 50% of ED cases.
- Research supports DBT's effectiveness in treating other complex disorders
- Eating disorders are complex & tend to have a chronic illness course
- Individuals with ED's tend to have multiple psychiatric comorbidities, complicating treatment.

- Comorbid BPD & parasuicidal behaviors are common among ED patients.
- Patients with ED's often have difficulty regulating their emotions and disordered eating behaviors may be a way to cope with this.
- DBT focuses on behavior; ED patients have specific behaviors that require modification. These become treatment targets.
- DBT might say that eating disorder behaviors help patients to "solve their own problems" as they lack skills to otherwise solve their own problems.

When to consider DBT for ED's

- Patients for whom traditional ED treatment has not been effective.
- Patients who present with significant emotion dysregulation.
- Patients who have co-morbid BPD.

Things to consider when using DBT to treat ED's

- Primary treatment target would be to achieve a balanced approach toward eating & food.
- Behaviors to increase would be following a structured meal plan, eating a variety of foods, improved identification of hunger and fullness cues.
- Behaviors to decrease include restrictive eating, avoidance of specific foods, compensatory behaviors, unstructured eating, judgements about weight, shape, & appearance.

ED-Specific Treatment Targets

- Target I: Life threatening behaviors
  - Bradycardia
  - Orthostatic blood pressure
  - Electrolyte imbalances
  - EKG abnormalities
  - Ipecac use

ED-Specific Treatment Targets

- Target II: Therapy-Interfering Behaviors
  - Not completing food diary cards
  - Not completing general diary card
  - Refusing to be weighed
  - Using behaviors to alter weight
  - Absence from treatment due to medical treatments
  - Purging that interferes with medication efficacy
  - Substance abuse

ED-Specific Treatment Targets

- Target III: Quality of Life Interfering Behaviors
  - Restriction/unstructured eating
  - Binge eating/purging
  - Diet pills/diuretic/laxative abuse
  - Overexercise
  - Calorie counting
  - Body checking
  - Avoiding food related events
  - Planning to diet

Additional Modifications to Consider

- Additional Skills
  - Nutrition module (basic nutrition education, regular eating, dieting myths, advertising, etc)
  - Expanded Mindfulness (mindful eating and body acceptance)
- Adapted Diary Card
  - Meal plan compliance
  - Track urges to use ED symptoms
  - Track other targeted ED behaviors

Sample DBT Diary Card

Dialectical Behavior Therapy Diary Card			How often did you fill out? Daily 2-3 times Once			Filled out in session? Yes No			MR#:			
Day	Date	Meal plan	Purging (# of times)	Laxatives	Self-harm	Meds Yes/No	Rating of Anxiety (0-10)	Depression/ Suicidal Thoughts Yes/No	Anger Yes/No	Used Support (Yes or No)	Exercise (Yes or No)/ (0-10)	Used Skills*
Sun												
Mon												
Tues												
Wed												
Thurs												
Fri												
Sat												

***Used Skills**

0 = Not thought about or used	4 = Tried, could use them, but didn't help
1 = Thought about, didn't use, didn't want to use	5 = Tried, could use them, helped
2 = Thought about, didn't use, but wanted to	6 = Didn't try, used them, didn't help
3 = Tried, but couldn't use them	7 = Didn't try, used them, helped

WEEKLY GOAL:

Urge to harm self (0-5) Before therapy session _____ After therapy session _____
Urge to quit therapy (0-5) Before therapy session _____ After therapy session _____

Teaching Protocols for Families or Groups

- Five Options for Solving Problems
- Combating Self-Criticism
- Seven Steps of Problem Solving
- Pros and Cons of Change
- STOP Technique
- Fairburn Emotion Regulation

5 Options in Responding to Any Problem

1) **Solve** the problems (address the person or situation; “fix it”)

2) **Change your emotional response** to the problem

3) **Tolerate the distress** caused by the problem and by your emotional response to it

4) **Stay miserable** or…

5) **Make it** (yourself of the situation) **worse**

Combating Self-Criticism

*Fennell, M: *Overcoming Low Self-Esteem*

What is the evidence?
- Am I confusing a thought with a fact?
- What is the evidence in favor of what I think about myself?
- What is the evidence against what I think about myself?

What alternative perspectives are there?
- Am I assuming my perspective is the only one possible?
- What evidence do I have to support alternative perspectives?

What is the effect of thinking the way I do about myself?
- Are these self-critical thoughts helpful to me, or at they getting in my way?
- What perspective might be more helpful to me?

What are the biases in my thinking about myself?
- Am I jumping to conclusions?
- Am I using a double standard?
- Am I thinking in all-or-nothing terms?
- Am I condemning myself as a total person on the basis of a single event?
- Am I concentrating on my weaknesses and forgetting my strengths?
- Am I blaming myself for things which are not really my fault?
- Am I expecting myself to be perfect?

What can I do?
- How can I put a new, kinder perspective into practice?
- Is there anything I need to do to change the situation? Even if not, what can I do to change my own thinking about it in the future?
- How can I experiment with acting in a less self-defeating way?

7 Problem-Solving Steps

Step 1: Identify the problem as early as possible

Step 2: Specify the problem accurately

Step 3: Consider as many solutions as possible

Step 4: Think through the pros and cons of each solution

Step 5: Choose the best solution or combination of solutions

Step 6: Act on the solution

Step 7: Evaluate the process of problem-solving

The Pros and Cons of Change

Reasons to stay as I am:
- If I change…
- If I change people will think that…

Reasons to change:

Looking ahead 5 Years

Reasons to stay as I am:
- If I change…
- If I change people will think that…

Reasons to change:

Conclusions:

I want to…(specific goal) because…

"Taking the Plunge"

STOP Technique

S- I'm starting to feel scared

T- I'm having the thought that …

O- Some other thoughts or behaviors to stay on track

P- Praise self for coping

FAIRBURN EMOTION REGULATION

Triggering Event:____
Thought:____
Feeling:____

Cognitive Amplification: "Loud Thoughts"

____

↓

Intense Wave of Emotion(s)

____

Urge for Action ↙ ↘ Tolerate

Dysfunctional Behaviors
1) Escape
2) Avoid
3) Maladaptive action

↓

Negative cognitive appraisal regarding self (eg: "I can't cope"/"I'm stuck")

Helpful Behaviors
1)Talk about it
2)Problem solve
3)Self soothing/relaxing

FAIRBURN EMOTION REGULATION GROUP EXERCISE

Triggering Event: felt full and found myself comparing my body to someone else's .
Thought: this might be eating disorder thinking .
Feeling: scared .

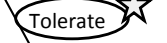
Cognitive Amplification: "Loud Thoughts"

not fair, this is too much food , I'm fat .

↓

Intense Wave of Emotion(s)

High Anxiety

Urge for Action ↙ ↘ Tolerate 

Dysfunctional Behaviors
1) Escape
2) Avoid
3) Maladaptive action-try to negotiate, get out of eating, pinching self

↓

Negative cognitive appraisal regarding self (eg: "I can't cope"/"I'm stuck")

Helpful Behaviors
1)Talk about it ✓
2)Problem solve ✓
3)Self soothing/relaxing ✓

GROUP EXERCISE

Skit 3: Adolescents sitting in a circle during a snack, comparing what was being eaten and their body sizes.

Positive Thoughts
- You did the right thing
- You will get home sooner
- You'll be with friends sooner
- You are much stronger
- This is your ED thinking
- You're beautiful
- The tallies are made for you exactly
- You are getting healthy
- You need the nutrition
- Just walk away
- Don't compare, you are better than that

Negative Thoughts
- You should take replacement
- You need to exercise
- You're fat
- You had way to much to eat
- The others had more choice
- Everyone else gets to stay thin
- Don't eat at your next meal
- You will never be good enough

Conclusions: It's helpful for parents to validate how you are feeling and to remind you that there is something fun to do afterwards.

Questions?

References/Recommended Reading

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