UNDERSTANDING AND TREATING ADOLESCENT EATING DISORDERS: THE ROLE OF THE PSYCHIATRIST IN FAMILY-BASED TREATMENT

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Definitions: Anorexia Nervosa

A. Restriction of intake leading to a significantly low body weight

B. Intense fear of gaining weight

C. Disturbed or distorted body image

Anorexia Nervosa

- Can have symptoms of:
  - —Restricting
  - —Exercising
  - —Binge-Eating
  - —Vomiting/purging
  - —Using diet pills or laxatives

Q: Adolescents with Anorexia Nervosa typically look underweight

A. True

B. False

C. Don’t know

Tip: Calculating %HBW:

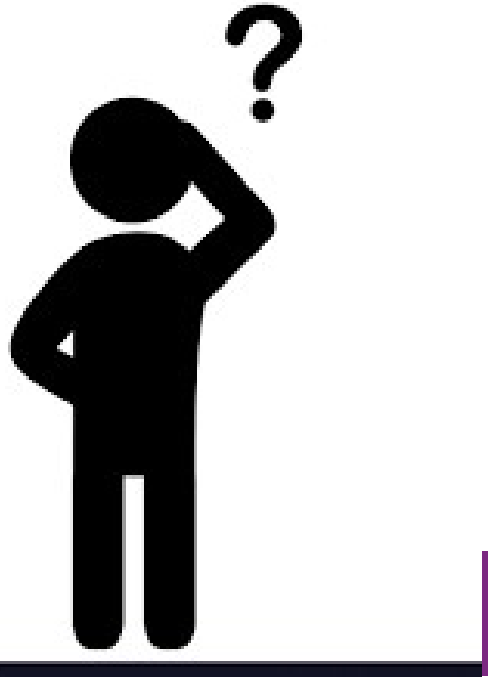
- Original weight: 200 lbs
- Current weight: 150 lbs
- % HBW: 150/200 x 100 = 75%

- **75% is dangerously low, likely associated with medical instability requiring hospitalization!**

We live in a culture where..

- Dieting, bingeing, self-induced vomiting, diet pills, laxative abuse are seen in more than 27% of Ontario girls aged 12 – 18 years
- One systematic review of 16 countries showed that 22% of children and adolescents have disordered eating
- Prevalence: 5-18% of adolescents and young adults have EDs

Understanding Eating Disorders



How To Create an ED:

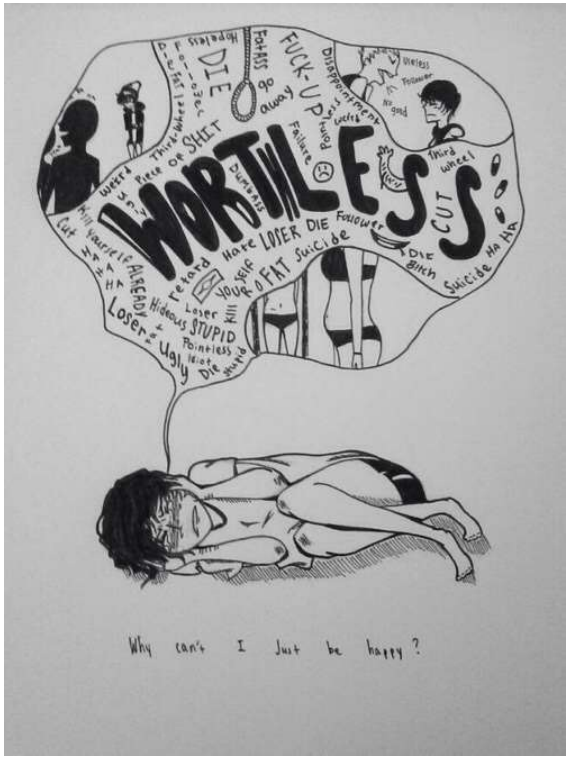
- Low self-esteem + stress, in a vulnerable individual = an ED

Eating Disorders Arise From A Place of:

- Feeling “not good enough”
- Low self-esteem
- Self-loathing
- Low mood
- Stress

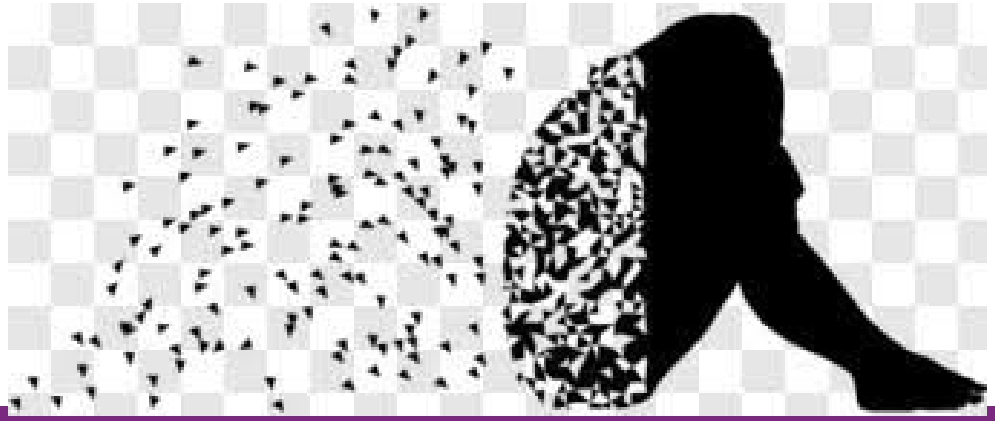
Eating Disorders are About:

Feeling worthless or as though you don't deserve to take up space in this world

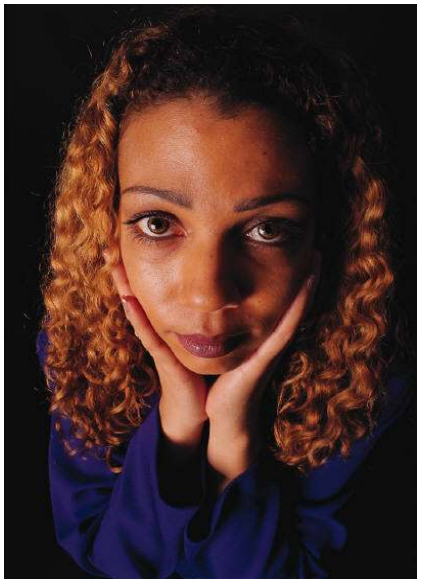


Eating Disorders are:

Associated with very high rates of depression and anxiety



The Development of an ED



Vulnerable Youth

- **Risk factors**
- **Sensitive / Low esteem**
- **Toxic Environment**
- **Comorbidities**

Stressors

Need to Gain Control / Feel Better

Dieting

Sense of Achievement

Increased Dieting

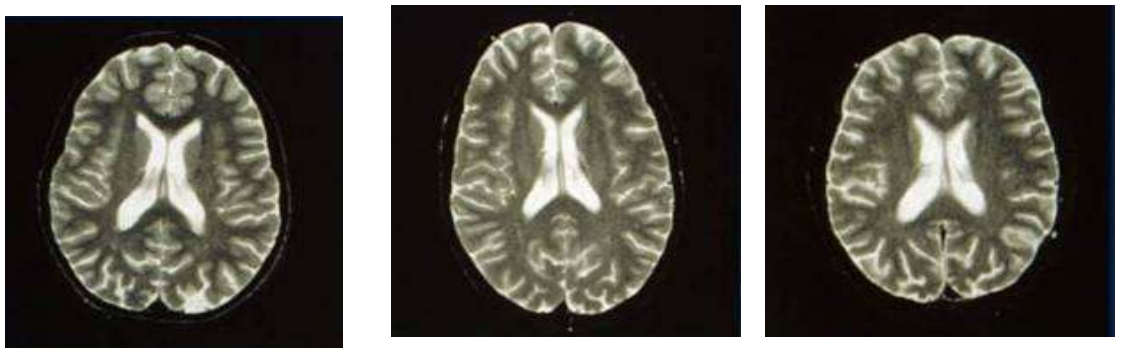
Snowballing of behaviours

Eating Disorder

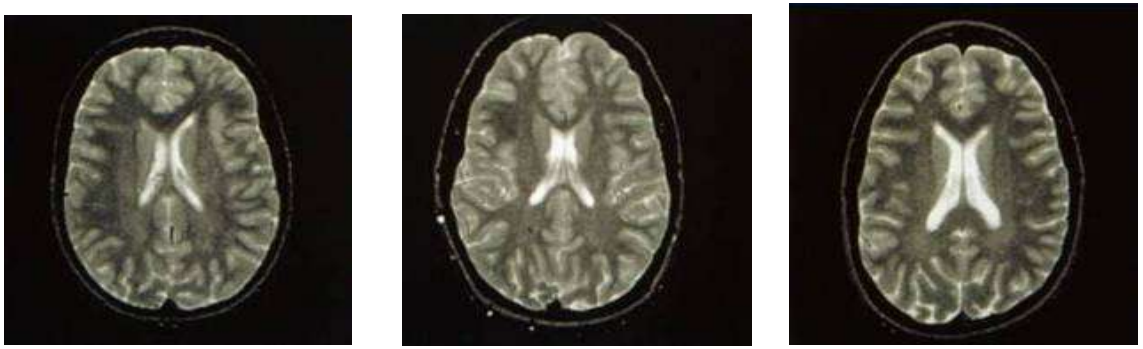
INSUFFICIENT NUTRITION HAS SERIOUS EFFECTS ON THE BRAIN, RESULTING IN PSYCHIATRIC SYMPTOMS

Structural brain changes MRI Findings - *Katzman et al, 1996*

Adolescent Females With AN



Adolescent Females Controls



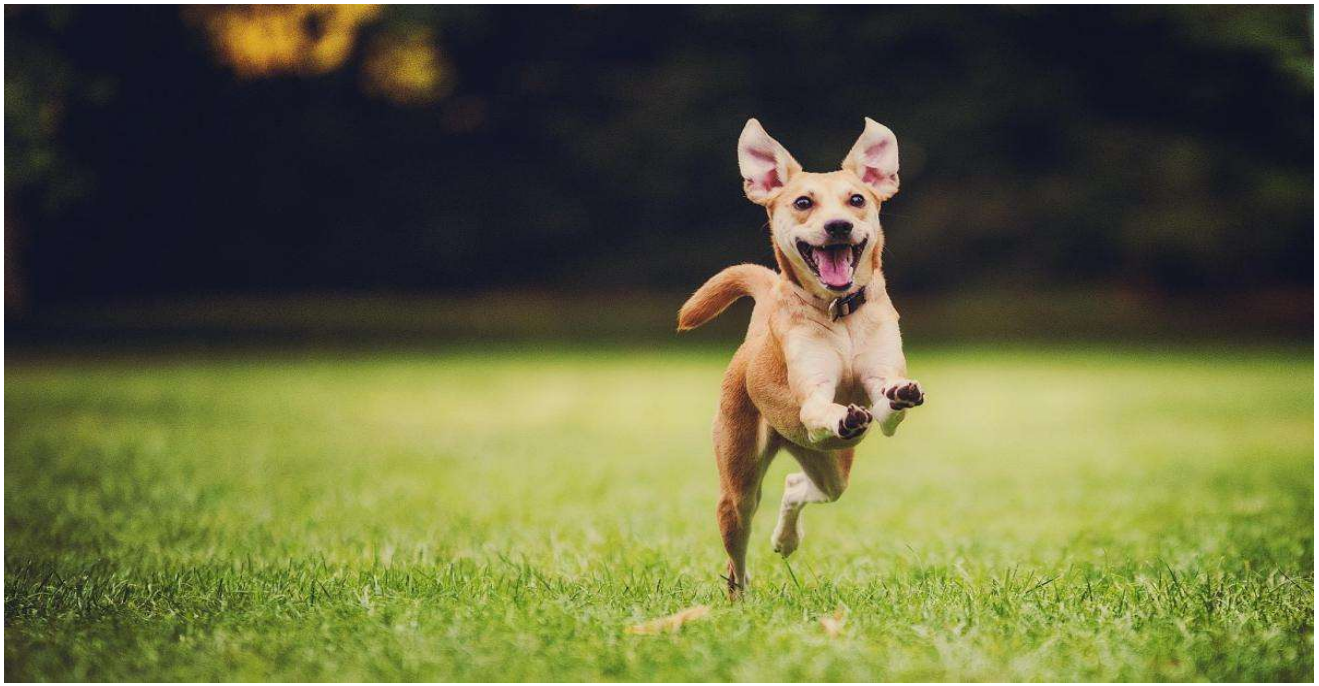
14 years **15 years** **16 years**

Psychological Effects of Starvation:

- Irritability and anger
- Emotional lability and dysregulation
- Depression; suicidality
- Anxiety
- Obsessiveness; obsessive ED thoughts; OCD; preoccupation with food and weight
- Rigidity and inflexibility; loss of humour
- Social withdrawal and isolation
- Insomnia
- Difficulty concentrating
- Restlessness and/or low energy

Starvation Affects Personality

In Dogs as Well As People:



An ED is Best Understood as Similar to Obsessive Compulsive Disorder:

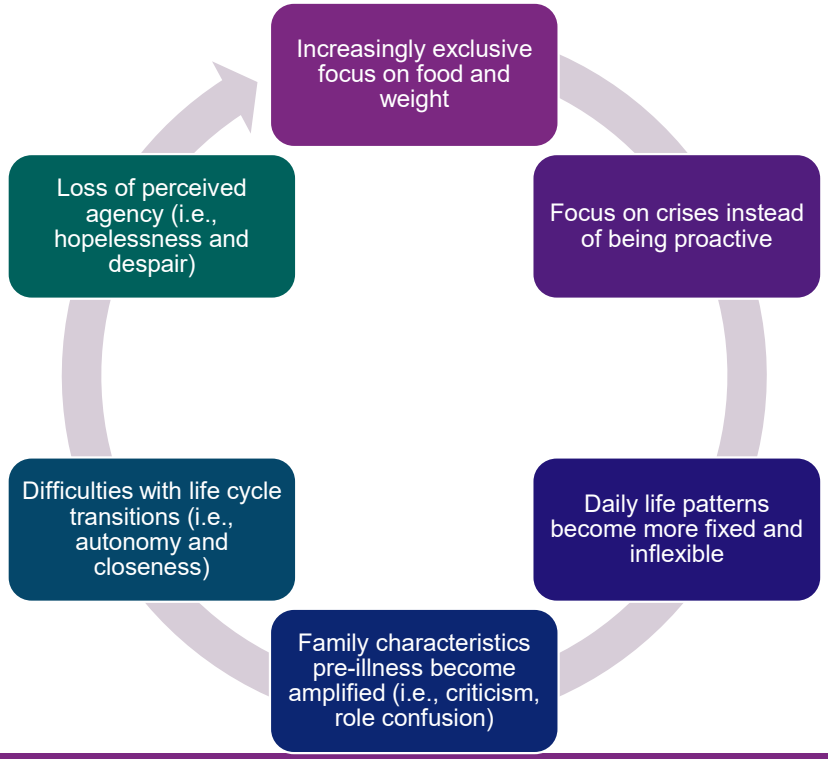
- As in OCD, the person can't tolerate the severe anxiety associated with the obsessive ED thoughts (eg "You're fat, don't eat that!"), and is compelled to have symptoms directed at weight loss.
- Eating or gaining weight causes the thoughts to get louder and is associated with anxiety, agitation and guilt
- Losing weight, or symptoms that cause weight loss, is associated with temporary relief

“You’re fat” “you’re eating too much” “Don’t eat that!” “You’re gaining too much weight!”

THERAPEUTIC UNDERSTANDINGS AND FAMILY INTERVENTIONS

Family Therapy underpinnings-- Maudsley
(Eisler et al., 2016)

Families become reorganized around their child(ren)'s difficulties with eating;

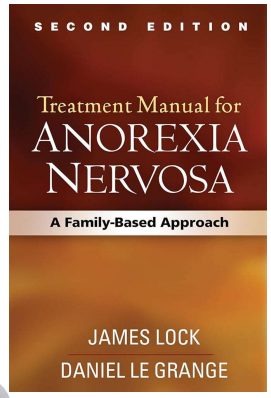


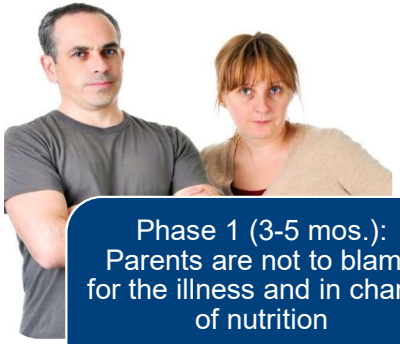
Outline of FBT

- 6 months – 1 year of weekly therapy (biweekly / monthly at the end)

- 3 stages
  - Regain of weight (most of focus); parents in charge
  - How adolescent can increase their own independence around food
  - Other issues present

Family Therapy underpinnings- Family Based Treatment (Lock & Le Grange, 2013)

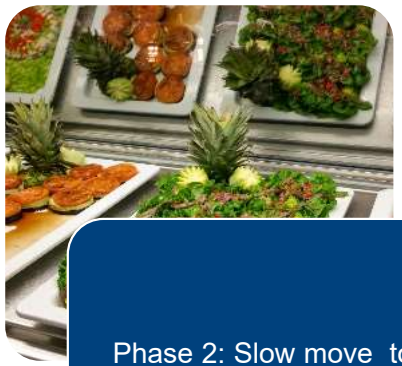




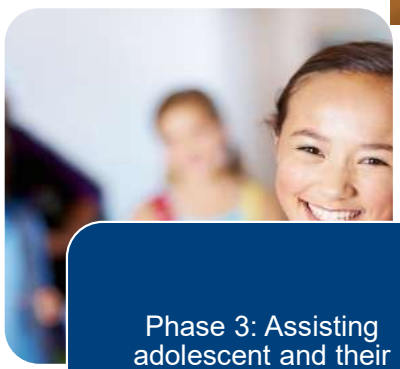
Phase 1 (3-5 mos.): Parents are not to blame for the illness and in charge of nutrition

adolescent seen as unable to control their behavior

Other developmental tasks and family conflicts put on hold to focus on re-nourishment.



Phase 2: Slow move to increasing adolescent autonomy regarding food, nutrition and weight



Phase 3: Assisting adolescent and their parents in moving towards typical developmental tasks (i.e., increasing autonomy and independence)

Which families

- Separated and Conjoint FT equally effective; separate critical parents
- Poorer prognosis associated with:
  - Inpatient treatment
  - Longer duration of illness
  - Greater weight loss
  - Maternal criticism
  - Psychiatric co-morbidity

THE ROLE OF THE PSYCHIATRIST

In treatment of Adolescent AN

GETTING STARTED:

TREATMENT BEGINS WITH THE FEEDBACK AT THE ASSESSMENT OR INITIAL SESSION

Talking to Patients:

- At the end of the assessment, provide feedback to the patient which:
  - Praises them, to help counter-act the “abuse” from the “ED voice” (eg. for their courage in coming today, for being able to talk, etc)
  - Externalizes the ED thoughts
  - Helps to lift shame and guilt
  - Helps them to feel understood (via the formulation, eg. all the reasons why they would understandably have felt bad on the inside, and how the ED makes that better)
  - Gives them hope

You Must Include Parents and Work Closely with Them:

- Family-Based Therapy (FBT) is the treatment of choice for adolescent AN and restrictive EDs
- The model is also useful, with some modifications, for B.N.
- Even if you don't do the family work yourself, it's crucial to respect, validate and empower parents, lift guilt, blame and anger, and help parents to understand the illness so they can best help their child to recover

Talking to Families: Externalize the Illness

Be very empathic and blame the illness; let the patient (and parents) hear that you understand that the ED won't let the young person eat, or won't let them eat normally, or won't let them keep it down. That it has become out of control now, and is causing terrible damage to her body, but it won't let her stop; it always tells her she's eating too much and gaining too much weight, and always makes her feel bad for eating. Compare the illness to a form of severe OCD.

Talking to Families:

You want the patient and parents to understand that the ED is an illness in which the patient feels better not eating, and worse when they eat. Thus, it is extremely difficult to eat one's way out of an ED; the ED always makes one feel bad/guilty/anxious for eating, and better for restricting or getting rid of the calories. ("The ED will punish your child when he tries to eat")

Talking to Families:

You have thus set the stage for the essential components: **praising the client** (since feeling bad fuels the ED), **lifting blame, raising anxiety** (re. the dangers of the illness), and pointing out that the ED won't let the patient eat enough (or keep it down), so that it is imperative that **caregivers step in** to support the client's recovery from this devastating, abusive illness

Talking to Families :

By pointing out that the ED makes “not eating feel good and eating feel terrible” you are acknowledging that this will be a terribly difficult process for the client, much like withdrawal from drugs, that the “ED will punish them every step of the way”, but that the alternative of leaving the client in the ED’s control is unacceptable (ie devastating complications)

The benefits of what you have just done:

- Challenged the denial that goes with the illness
- Mobilized parents to follow through on help for their child
- Normalized the client's fear and resistance
- Allowed parents to accept that anger or tears are to be expected; that this will be extremely difficult and the young person will need all of their compassion, support and understanding (vs anger, frustration)

The benefits of what you have done cont'd:

- Helped parents send a message to their child that nothing is as important to them as her well-being
- Helped the client feel understood, and given them hope
- Started separating the patient from the illness
- Started the process of turning the patient against the illness

Final Feedback to the Family:

At the end of the assessment, during feedback to the family, you stress the necessity of close medical and nutritional management, plus psychological treatment, for this severe medical and mental illness

PSYCHIATRIST AS THERAPIST

Climbing the mountain of recovery

Next Steps:

- Make sure the client is medically stable!
- Focus on nutrition and symptom interruption as a priority; **weekly weight graph**
- Work closely with parents
- Psychoeducation for client and parents
- Address psychosocial stressors, eg. school, peers, family
- Treat co-morbidities after or during renourishment and symptom-containment

Key principles in FBT Stage 1

- Compassionate and uncritical stance
- Externalizes the illness
- Lift blame and guilt
- Raise anxiety (vs. denial)
  - Alarms and mobilizes the family re dangers of Anorexia Nervosa and need to prioritize treatment and weight gain
  - Often compare giving the correct ‘dose’ of nutrition to giving the correct ‘dose’ of insulin for diabetes
- Empower parents
  - They are the best ones to save their child
  - Charged with task of re-feeding their child

Other key steps:

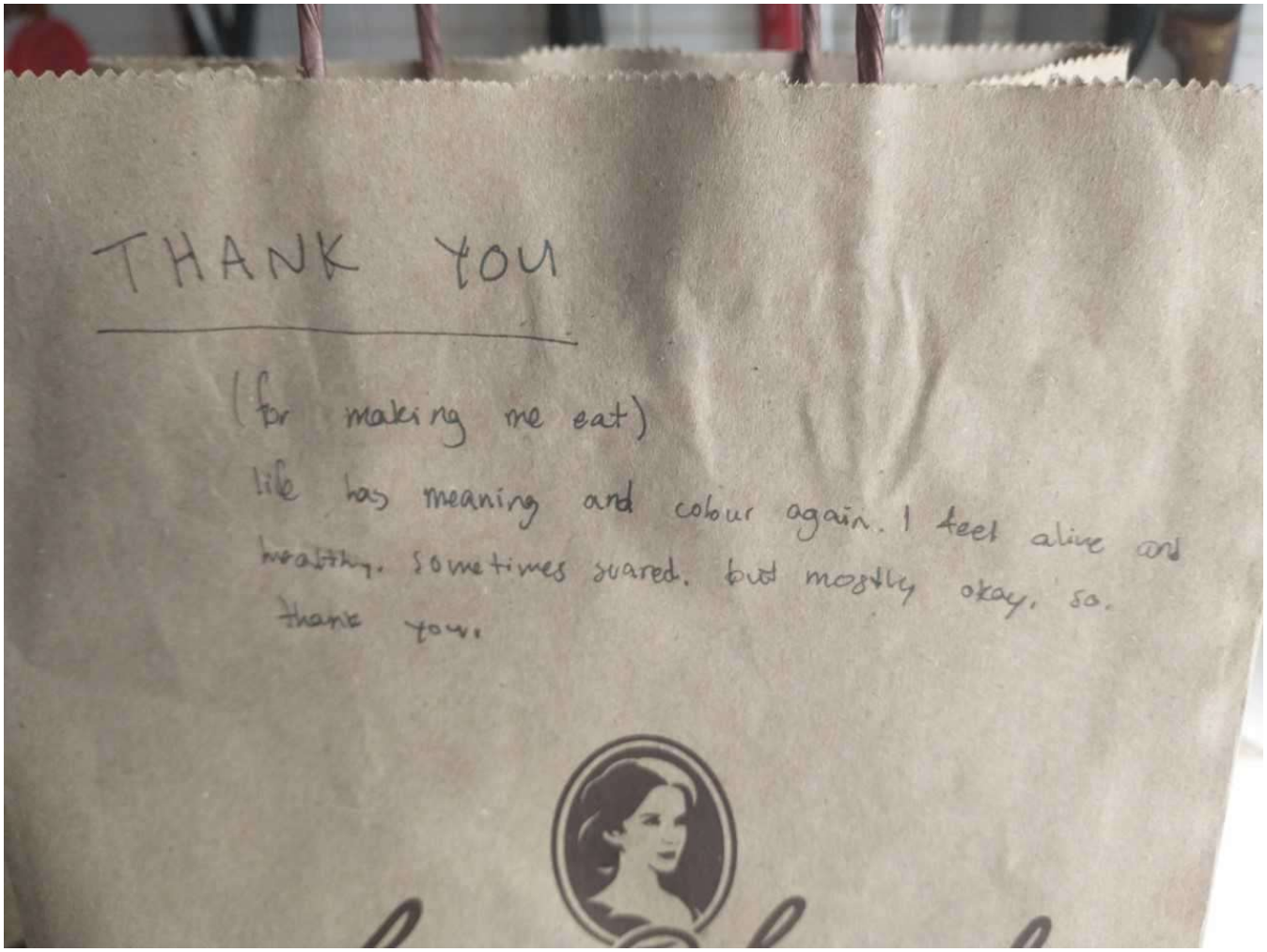
1. **Connecting with the youth** – they see that we understand their experience, and we will not leave them alone with their ED, but understand their torture
2. **Supporting process** of "We know how difficult this is for you / we love you, AND it is not an option not to eat"
3. Asking parents to be on the **same page**
4. Using **siblings** as support for the patient
5. **Separating** patient from the illness
6. Helping to diminish parental **criticism** if present (Often a sign that parents are blaming themselves or do not yet fully understand the illness)

We Also Give Parents Tips to Decrease Anger and Resistance in the Client:

- We teach parents the same approach to supporting their child that we use:
  - Low expectations
  - Non-negotiables (firmness)
  - ++ Empathy (gentleness)
  - Help the youth have a voice

- "Lowering blame and enhancing family problem solving" (Le Grange et al 1992)

The family's compassion, love, and unconditional acceptance help the client to feel "good enough"


THANK YOU
(for making me eat)
life has meaning and colour again. I feel alive and
healthy. sometimes scared. but mostly okay. so.
thank you.

PSYCHIATRIST AS CONSULTANT

Typical Recommendations

Recommended Treatment for Anorexia Nervosa:

- Medical management
- **Family Based Therapy (FBT)** whenever possible, focused on the goal of increasing intake and weight.
- Treatment of co-morbidities, e.g. anxiety, depression, emotion dysregulation, substance abuse, PTSD...
- Antipsychotics might be used when they are very low weight and struggling
- SSRIs (eg. Prozac) to treat depression and anxiety after renourishment has begun and weight is increasing

AN - Medication

- SSRI's / antidepressants
  - do not seem to work when weight is too low
  - Can use after weight restoration – to treat depression and/or anxiety

- Atypical antipsychotics
  - Limited evidence (but clinically frequently used to help patients gain weight or get 'unstuck,' esp. **Olanzapine**)
  - Need to monitor for side effects

Weight Gain is Necessary But Not Sufficient:

- The client needs to know that you won't just take away their ED/coping strategy and "send them back" to how they felt before the ED
- Address/treat the "intolerable feelings" and the reasons the client feels "not good enough", e.g.,
  - School?
  - **Anxiety? (esp. social anxiety)**
  - **Perfectionism?**
  - **Self critical thoughts**
  - Depression?
  - Peers? Family?

KEY MESSAGES

Key Messages:

- Insufficient nutrition with weight loss can lead to serious medical and psychological consequences in youth
- Insufficient nutrition can mimic mental illness, including causing irritability, depression, suicidality, anxiety, obsessiveness, insomnia and mood dysregulation
- Medication can’t work and clients can’t get better unless they are eating enough to gain weight and get up to their healthy weight.

Key Messages:

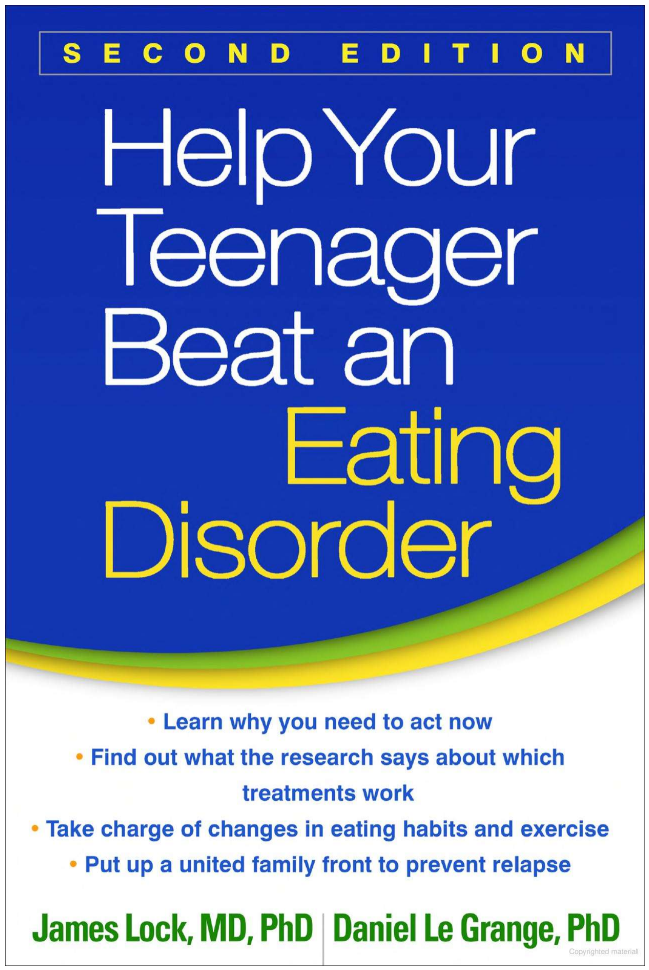
- An ED arises from a youth's stress and self-loathing, and is not a "choice"
- An ED is probably best compared to severe OCD; symptoms are compulsive
- Treatment needs to address medical, nutritional and psychological needs
- Treatment needs to involve partnering with parents/caregivers and empowering them to take charge of nutrition, using family based therapy

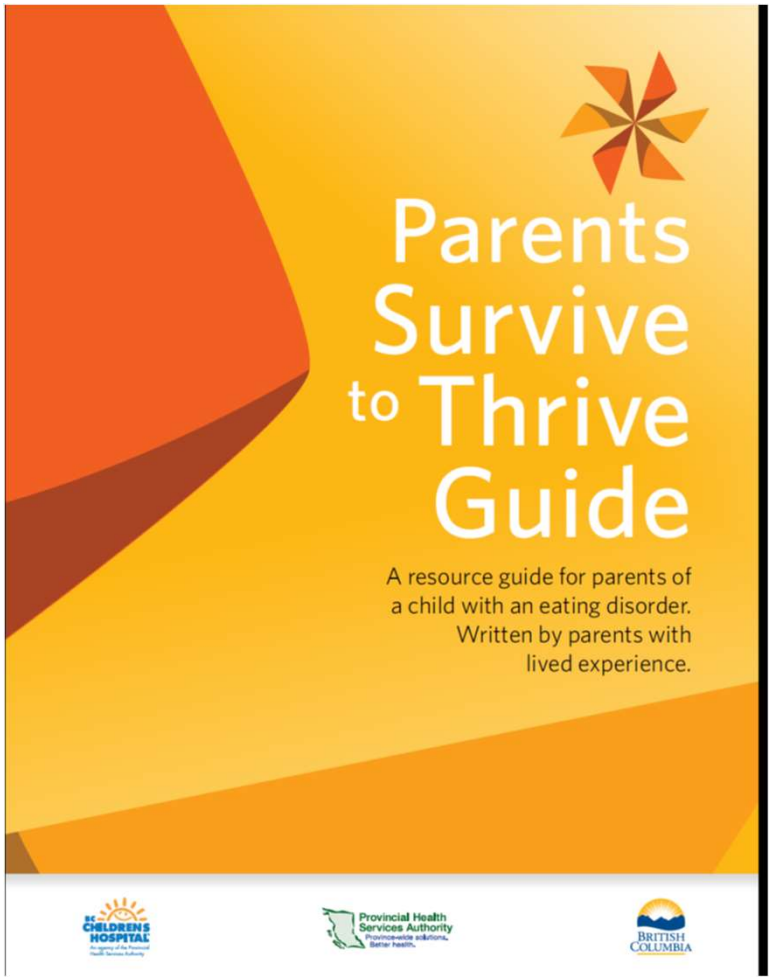
QUESTIONS?

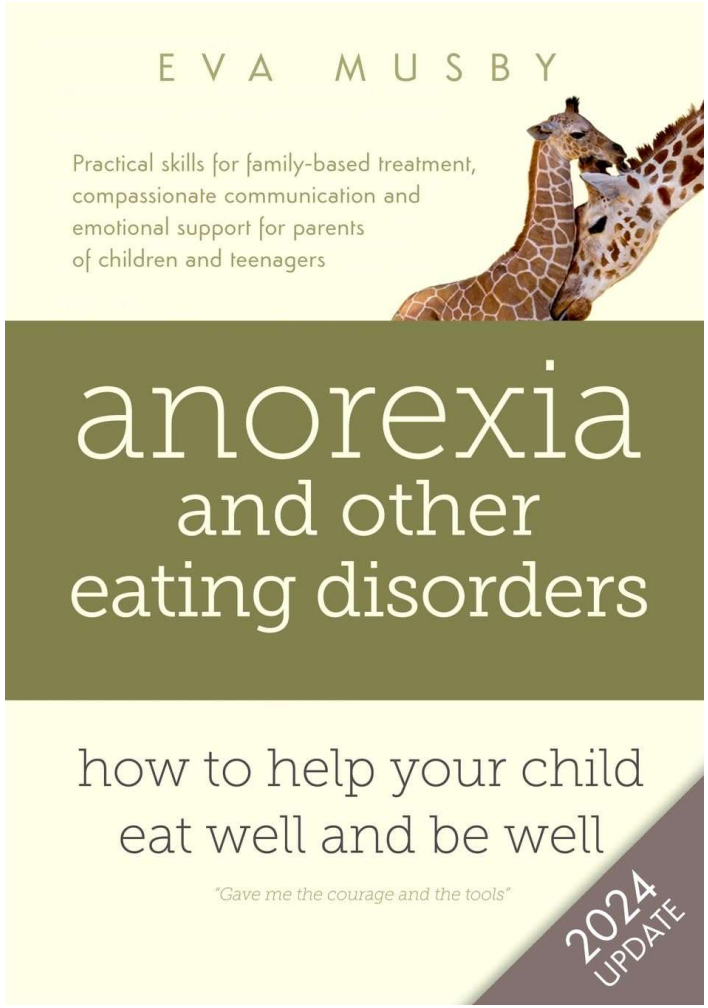
DISCUSSION

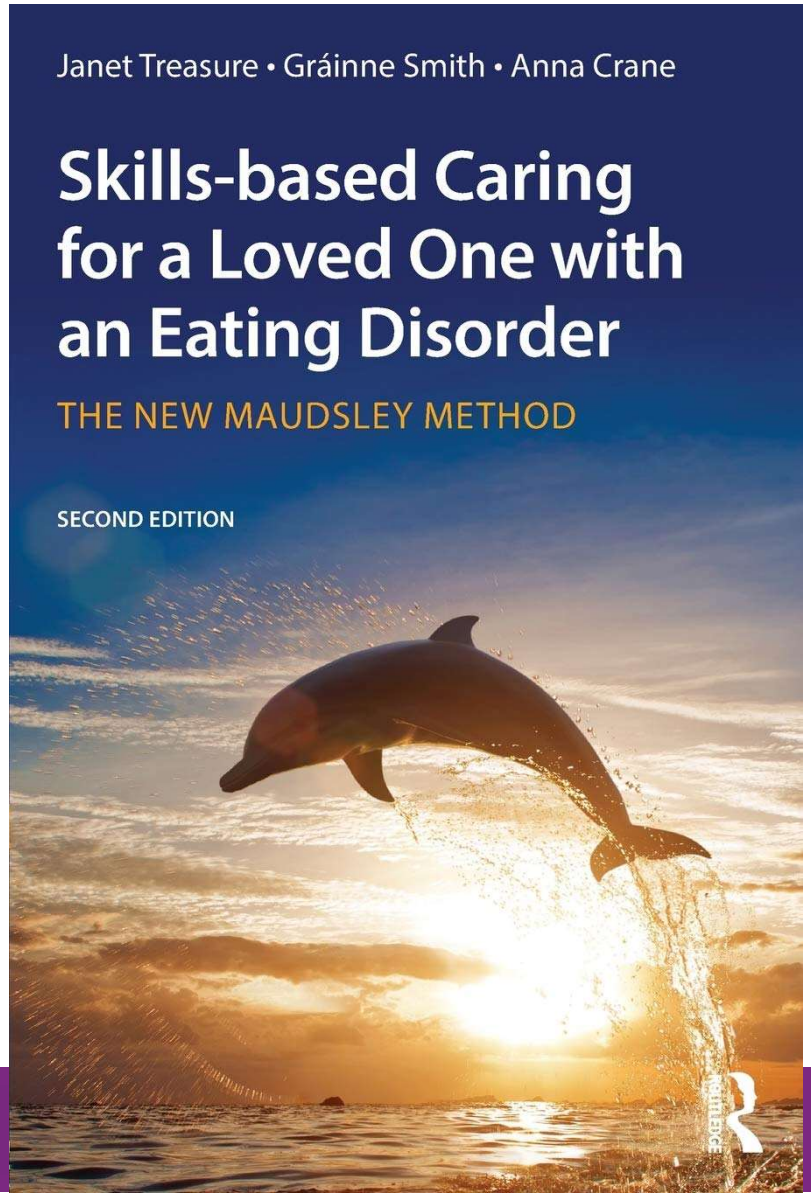
Helpful Eating Disorder Websites:

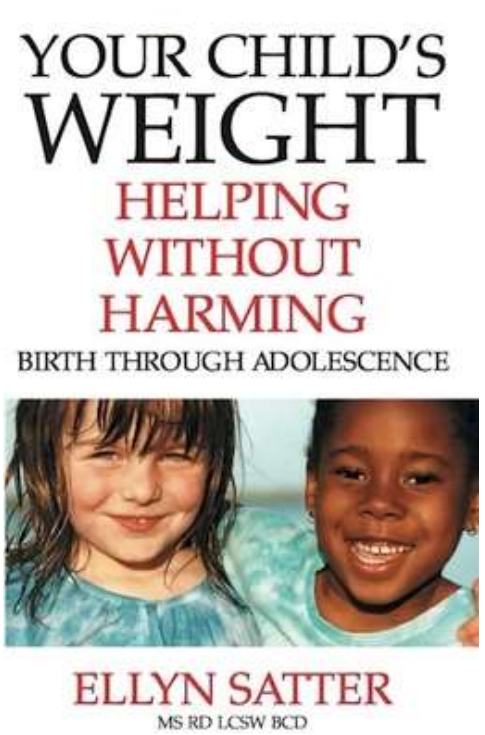
- www.nedic.ca; www.nied.ca
- www.canped.ca
- https:/keltyeatingdisorders.ca
- https://www.youtube.com/evamusby
- www.nationaleatingdisorders.org
- www.facebook.com/groups/International.Eating.Disorder.Family.Support.IEDFS/
- www.empoweredparents.com; www.empoweredkidZ.com
- www.treatingeatingdisorders.com
- www.MaudsleyParents.org; www.AroundTheDinnerTable.org
- www.eatingwithyouranorexic.blogspot.com
- www.anorexiafamily.com' www.something-fishy.org
- https://ceed.org.au/resources-and-links/
- https://freedfromed.co.uk/

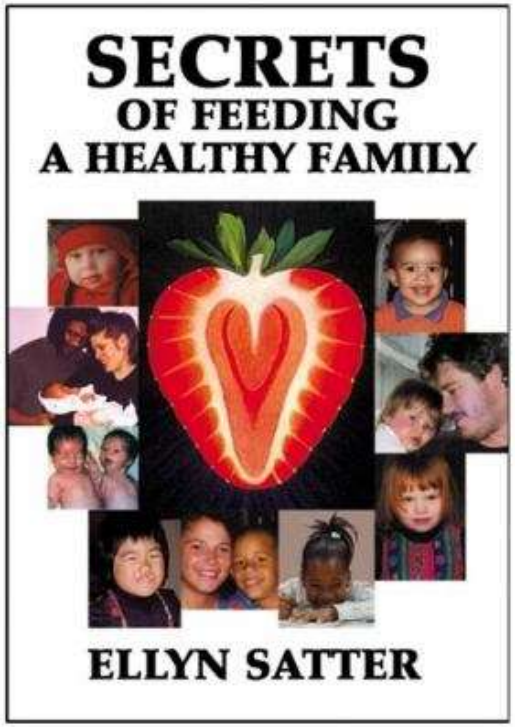

SECOND EDITION
Help Your Teenager Beat an Eating Disorder
• Learn why you need to act now
• Find out what the research says about which treatments work
• Take charge of changes in eating habits and exercise
• Put up a united family front to prevent relapse
James Lock, MD, PhD
Daniel Le Grange, PhD


Parents Survive to Thrive Guide
A resource guide for parents of a child with an eating disorder. Written by parents with lived experience.
BC Children's Hospital
Provincial Health Services Authority
Province-wide solutions. Better health.
British Columbia


EVA MUSBY
Practical skills for family-based treatment, compassionate communication and emotional support for parents of children and teenagers
anorexia
and other
eating disorders
how to help your child eat well and be well
"Gave me the courage and the tools"
2024 UPDATE


Janet Treasure • Gráinne Smith • Anna Crane
Skills-based Caring for a Loved One with an Eating Disorder
THE NEW MAUDSLEY METHOD
SECOND EDITION


YOUR CHILD'S
WEIGHT
HELPING
WITHOUT
HARMING
BIRTH THROUGH ADOLESCENCE
ELLYN SATTER
MS RD LCSW BCD


SECRETS
OF FEEDING
A HEALTHY FAMILY
ELLYN SATTER