FAMILY-BASED TREATMENT OF PATIENTS WITH EATING DISORDERS: FAMILY SYSTEMS CHALLENGES AND OPPORTUNITIES

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THRIVE

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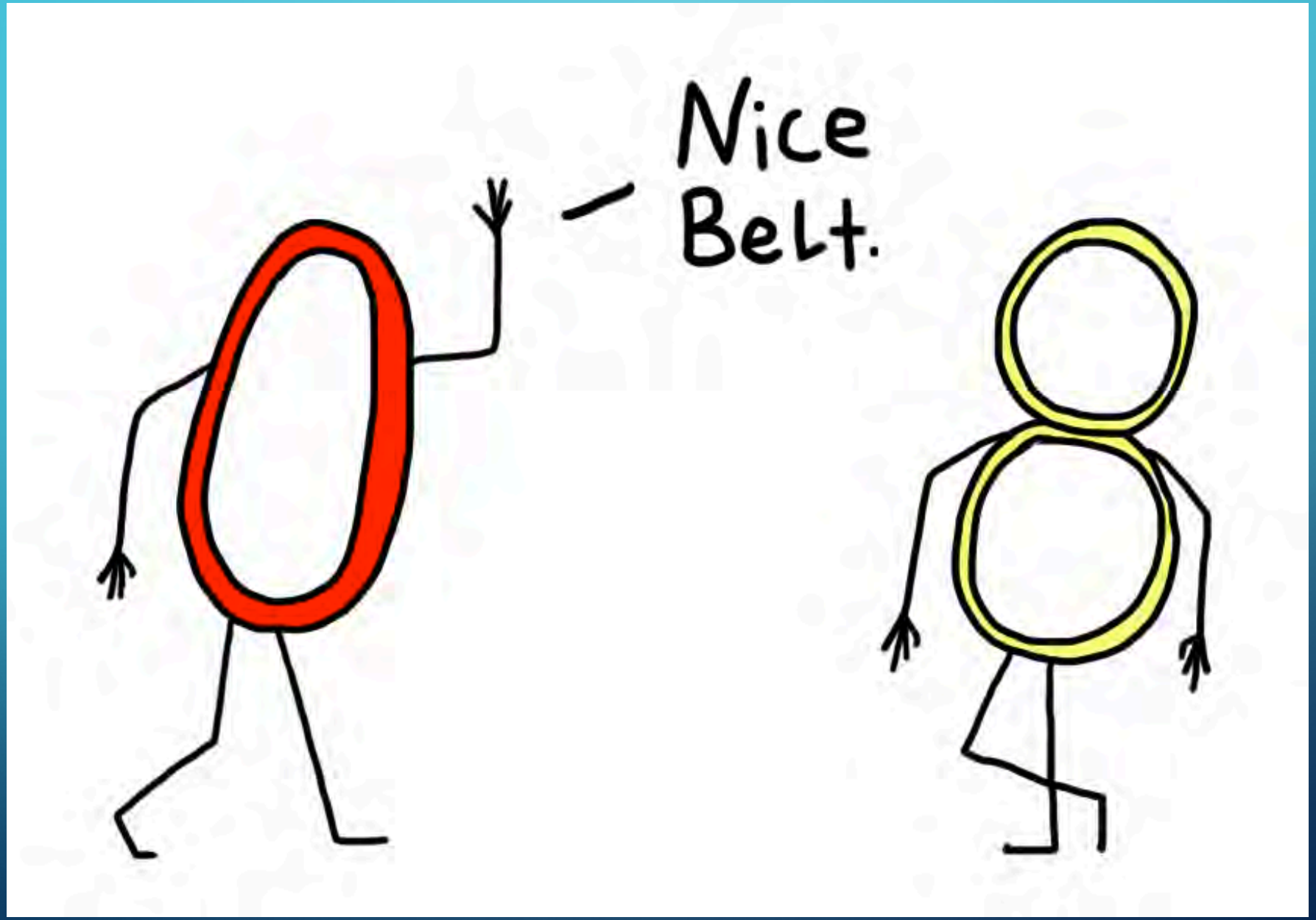
FAMILY SYSTEMS CHALLENGES AND OPPORTUNITIES: OBJECTIVES

- Participants will develop an understanding of the Family-Based Integrated Care Framework as a applied to patient assessment, formulation, and family communication.
- Participants will become familiar with common family systems challenges in the context of treating children and teens with eating disorders.
- Participants will learn about some tools to support productive conversations in the context of these family systems challenges.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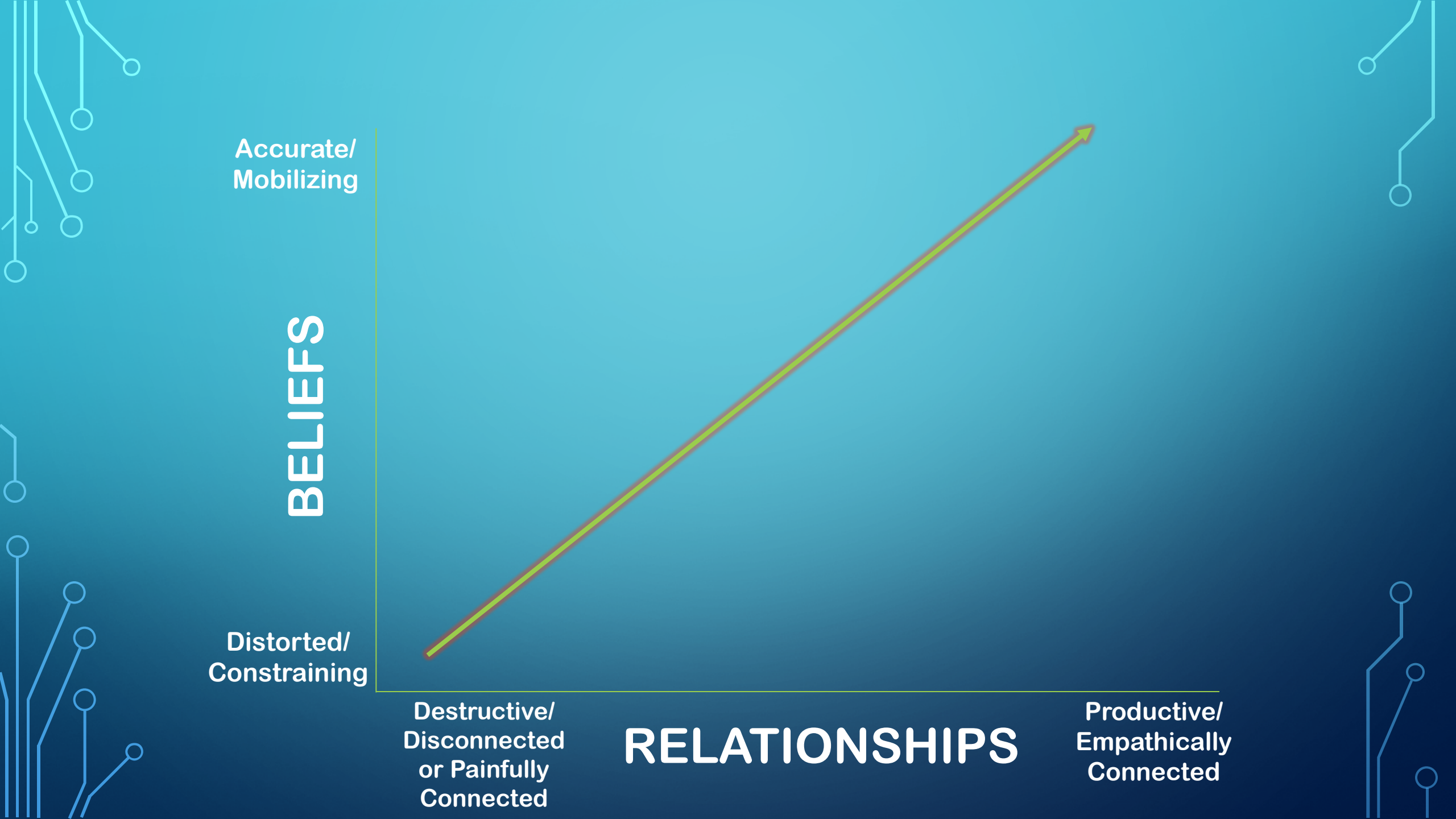
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FBIC - THE BIG PICTURE

- What is family-based integrated care?
  - An empowering perspective about symptoms and illness focusing on supporting accurate beliefs and healthy family relationships in the context of illness crises
- Relationships
  - Destructive, disconnected, or painfully connected → productive and empathically connected
- Beliefs
  - Distorted/ Constraining> Accurate/Mobilizing
- Team Model
  - Message Magnification

“FAMILY-BASED”

- Not simply “involving” or “updating” the family
- Not just using family therapy as a treatment modality
- Making every decision from the perspective that family illness beliefs and family relationships together constitute the two most powerful forces in illness management/recovery

"INTEGRATED"

- Not simply communication between medical and psychiatric providers
- Not simply the concept of integrating physical and psychological issues in treatment
- The integration of modalities (pediatric care, psychotherapy, case management, ancillary service care, psychopharmacology) through consistent provider communication and the ***provision of coordinated messages to families***

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

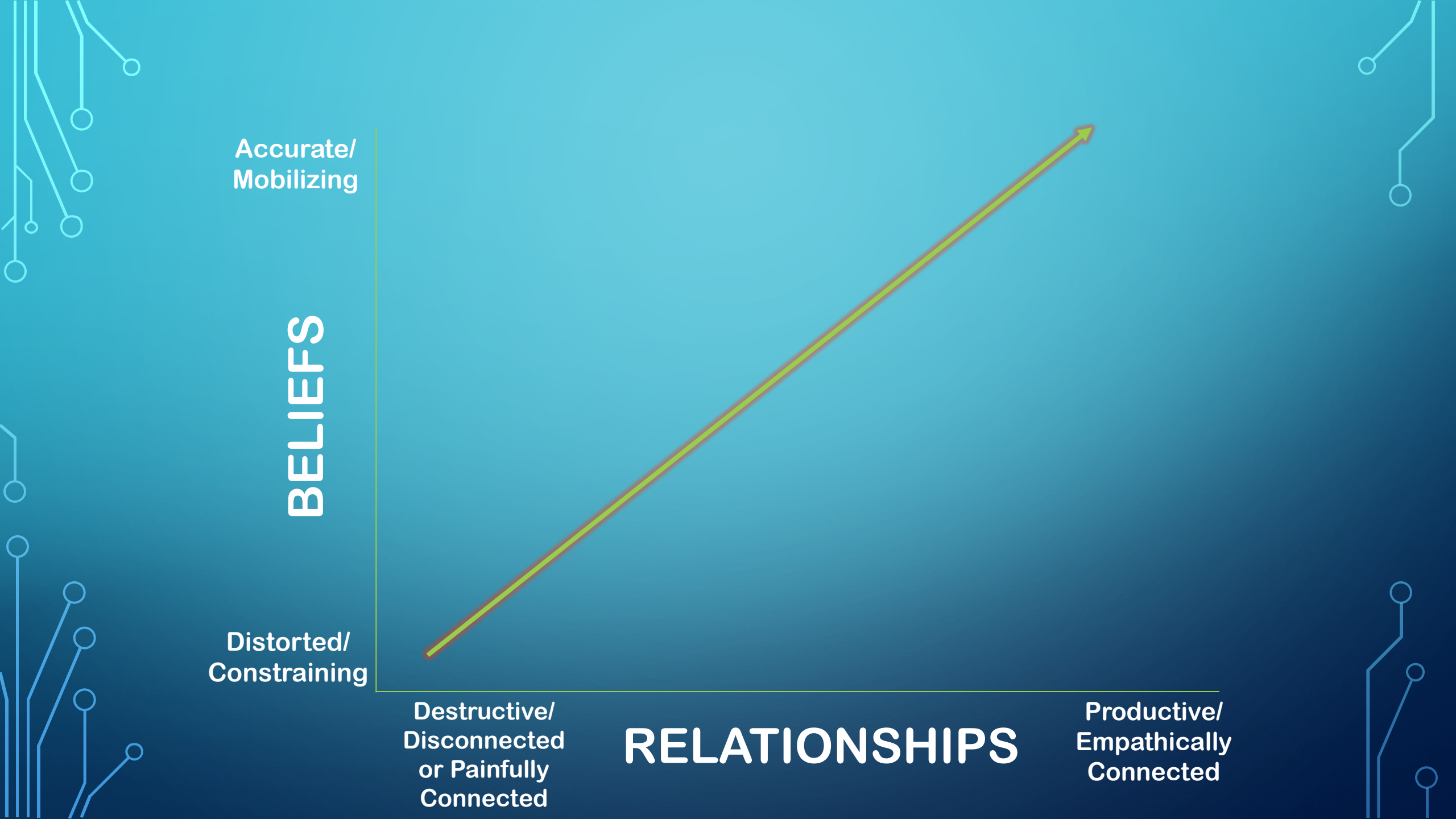
- It is a very common phenomenon that even parents who are parenting under one roof have very different personalities and/or parenting styles.
- JOINED AND ACCURATE MESSAGES FROM PARENTS ARE THE MOST IMPORTANT PART IN RECOVERY.
- The longer mixed messages/splits persist the harder the ED will be to treat.
- 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

- Consider using the FBIC “graph” to orient you about the “big picture” of the case
  - Focus treatment goals in a realistic way
  - Increased ease/empathy joining with families who may be ”in the lower corner of the graph”
- Be aware of the power of messages to patients and families
  - Keep it simple
    - Externalizing the illness
    - Pain doesn’t have to be destructive, it can be productive
  - 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