Intermountain Project ECHO
Dementia Care

FAMILY BASED THERAPY
for Adolescent Anorexia Nervosa

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Disclosures

The speaker has no significant financial conflicts of interest to disclose.
HISTORY

• Maudsley Hospital London; “The Maudsley Approach” - 1970s/1980s
  
  o Dr. Christopher Dare and colleagues first to implement philosophy and intervention and begin conducting research.

  o Maudsley Service Manual for Child and Adolescent Eating Disorders (revised 2016)

HISTORY

• Manualized in United States

  o Daniel LeGrange, PhD and James Lock, MD (1990s on).

  o Treatment Manual for Anorexia Nervosa; A Family Based Approach (2nd edition 2013).

  o Training Institute for Child and Adolescent Eating Disorders.

  o http://train2treat4ed.com/
Philosophy – Out with the old in with the new

• Old Philosophy
  o Ed is a result of dysfunctional family dynamics (blaming parents).
  o Adolescent chose to have an eating disorder and will need to want to get better (blaming client).
  o Therapy must address the root cause before the client will get any better.
  o Individual therapy and in-patient care.

• New philosophy
  o Parents nor client are to blame.
  o Parents are a key resource for recovery and are the experts on their children and their family.
  o Full nutrition is necessary for recovery from Anorexia Nervosa.
  o Parents can and must require their child to eat the types and amounts of food needed to recover.
  o Outpatient therapy.
  o Therapist is a consultant/coach to the family as they work toward recovery.
RESEARCH OUTCOMES

• 20 plus years and continuing.

• Illness for short period of time (less than 3 years) and early onset (under 18).

• Supports efficacy of FBT for treatment of Anorexia Nervosa in adolescent population.

• Quicker return to healthy weight and normal eating behaviors.

• Higher percentage in remission at follow up.
OVERVIEW

• Outpatient

• Parents take charge of food until adolescent can take it over.

• Therapist is a consultant to the family coaching them in re-feeding and returning to pre-eating disorder.

• Entire family is involved

• 3 Phase treatment

• 15-20 treatment sessions over a 12 month period
PHASE ONE – Weight Restoration

THERAPIST
• Provides psychoeducation on dangers of associated severe malnutrition.
• Assesses families typical interaction patterns and eating habits.
• Family meal in therapist office.
• Models non critical and non-confrontational approach.
• Session focus: What is working, what is not, and therapist supports/coaches parents and client in finding and implementing solutions. Empower parents.
• Treatment with family as opposed to treatment of family.

PARENTS
• Take charge of food: make and plate types and amount of food needed for weight restoration.
• 1-3 pounds a week.
• Client is not in charge of food: what, where, when, how.
• Client is required to eat what is provided.
• Re-align client with siblings and family norms around food.
PHASE TWO: Returning control of eating over to adolescent

Client demonstrates ability to eat what is provided, steady weight gain of about 1-3 pounds a week, improvement in client and family mood, decrease in ED behaviors, and generalized anxiety around ED.

- Client begins step by step to take charge of his or her eating (developmental and family norms apply).
- Weight is monitored and should continue to increase toward maintenance.
- Continued coaching and exploration into day to day family dynamics/client barriers that interfere with parents' ability to support continued weight gain and the decline of ED behaviors.
PHASE THREE: Establishing healthy adolescent identity

Adolescent demonstrates ability to keep weight at maintenance and ED behaviors have subsided; eating on own.

- Support family and client in re-establishing identity outside of ED.
- Support relapse prevention plan and strategies for continued success with recovery behaviors.
- Identify and address client’s existing mental health needs, absent of the ED.
- Identify and address existing family therapy needs, absent of the ED.
- Potentially refer client and/or family out.
ROLE of ED TEAM

Physician: Due to medical complications associated with Anorexia Nervosa client will always work directly with a medical doctor.

Dietician: Utilized on an as needed basis. Will join therapy session with therapist to coach parents if needed.

Weight Checks: Traditionally in therapist office, not blind.
CONTRAINDICATIONS

• Complicating family dynamics (ED parent, substance use, abuse...)

• Logistics (work, single parent...)

• Comorbidity (Autism, significant self-harm behaviors, severe persistent mental illness)
THE FUTURE

• Research being conducted on FBT for BN as well as young adults.

• Fidelity – Are therapists using the manualized protocols?

• Expansion on the current models.

• Continued research on alternative interventions.
APPLIED FBT

Two case studies to explore...
REFERENCES


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This activity has been approved for 1.5 CEUs from the National Association of Social Workers Utah Chapter.

Requests for CPEUs from the Commission on Dietetic Registration are pending.