The Hitchhiker's Guide to Eating Disorders

Don't Panic!

BC MENTAL HEALTH & SUBSTANCE USE SERVICES
An agency of the Provincial Health Services Authority

Outline for PM session

- Case management in the community - Karen
- FBT - Karina
- Traditional family therapy - Karen
- Meal Support – in hospital and at home – Tom, Judy, Cathy

A Pitch for Case Management!

- Medical, psychiatric aspects of illness
- Need for multi-disciplinary involvement
- Decision-making around which treatment modalities are possible and needed
- Referrals

A Pitch for Case Management!

- Long term often non-linear recovery, 3-5 + years
- Moving in and out of, and need for various systems – transitions are stressful, planning is essential
- Essential need to coordinate communication, updates, changing needs

Illustrative Example

- Jane, 14 years old
- Home from 2 week hospitalization for medical stabilization & ng feeds after 5 consecutive days of no food intake, only water.
- Anorexia Nervosa, restrictive subtype (new diagnosis),
- MDD and GAD (both diagnosed prior to ED diagnosis).
- Self harms by cutting forearms.
- Weight at discharge 80% SBW.
- Medications: fluoxetine 40 mg daily.
- Lives primarily with her mother and younger brother Jack, age 09.
- Parents are divorced and do not communicate easily without arguing. They share custody. The children go to stay with their father every other weekend. Both parents would like to try FBT.
- Excels academically but struggles socially since entering high school - was bullied by female peers in her class. Has been attending school intermittently since ED diagnosis.

Biopsychosocial Formulation

	Protective/ Strengths	Predisposing	Precipitating	Perpetuating
Biological:				
Psychological:				
•Individual				
•Family				
•Social/ Cultural				

Partial Formulation from Example

	Protective/ Strengths	Predisposing	Precipitating	Perpetuating
Biological:	?	MDD GAD	?	Low weight MDD GAD
Psychological:				
•Individual	Excels academically Coping via self harm	?	?	Experienced bullying: trauma Struggling socially Maladaptive coping (cutting)
•Family	Parents invested in working toward recovery: would like FBT Sibling for support	?	?	Two households Parents don't communicate easily and argue
•Social/ Cultural	?		?	Unsafe school environment

Family Based Therapy

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What is FBT?

- At least 3 decades of research support the use of family therapy in the treatment of adolescent Anorexia Nervosa
- More recently research has focused on a specific type of family therapy known as FBT, or the Maudsley approach.

Research Support

ORIGINAL ARTICLE

Randomized Clinical Trial Comparing Family-Based Treatment With Adolescent-Focused Individual Therapy for Adolescents With Anorexia Nervosa

James Lock, MD, PhD; Daniel Le Grange, PhD; W. Stewart Agras, MD; Ann Moye, PhD; Susan W. Bryson, MA, MS; Bonil Jo, PhD

Context: Evidence-based treatment trials for adolescents with anorexia nervosa are few.

Objective: To evaluate the relative efficacy of family-based treatment (FBT) and adolescent-focused individual therapy (AFT) for adolescents with anorexia nervosa in full remission.

Design: Randomized controlled trial.

Setting: Stanford University and The University of Chicago (April 2005 until March 2009).

Participants: One hundred twenty-one participants, aged 12 through 18 years, with DSM-IV diagnosis of anorexia nervosa excluding the amenorrhea requirement.

Intervention: Twenty-four outpatient hours of treatment over 12 months of FBT or AFT. Participants were assessed at baseline, end of treatment (EOT), and 6 months' and 12 months' follow-up posttreatment.

Main Outcome Measures: Full remission from anorexia nervosa defined as normal weight (≥99% of expected for sex, age, and height) and mean global Eating Disorder Examination score within 1 SD of published means. Secondary outcome measures included partial remission rates (≥85% of expected weight for height plus those who were in full remission) and changes in body mass index percentile and eating-related psychopathology.

Results: There were no differences in full remission between treatments at EOT. However, at both the 6- and 12-month follow-up, FBT was significantly superior to AFT on this measure. Family-based treatment was significantly superior for partial remission at EOT but not at follow-up. In addition, body mass index percentile at EOT was significantly superior for FBT, but this effect was not found at follow-up. Participants in FBT also had greater changes in Eating Disorder Examination score at EOT than those in AFT, but there were no differences at follow-up.

Conclusion: Although both treatments led to considerable improvement and were similarly effective in producing full remission at EOT, FBT was more effective in facilitating full remission at both follow-up points.

Trial Registration: clinicaltrials.gov Identifier: NCT00149786.

Arch Gen Psychiatry. 2010;67(10):1025-1032

Lock et al. (2010)

- 12 months of therapy
  - FBT vs. adolescent-focused therapy (individual)
  - AFT: identify emotions & tolerate emotional states, with weight-related goals (32 sessions, 45 min each)
  - FBT: 3 phases (24 1-hour sessions)

Lock et al. (2010): Outcomes

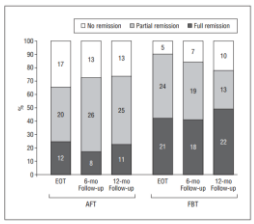


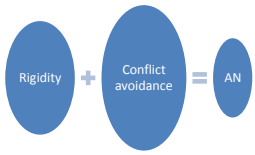
Figure 2. Observed partial and full remission rates by treatment assignment (end of treatment [EOT]: adolescent-focused individual therapy [AFT], n=49; family-based treatment [FBT], n=50; 6-month follow-up: AFT, n=47; FBT, n=44; and 12-month follow-up: AFT, n=49; FBT, n=45).

Treatment for Bulimia Nervosa (Adolescents); LeGrange et al. 2007

- Family Therapy vs. supportive psychotherapy (6 months)
  - RCT: n = 41 FBT; n = 39 SPT
- Higher abstinence from binge/purge in FBT in comparison to SPT
  - Post-treatment: 39% vs. 18% , p < .05
  - 6-mo follow-up: 29% vs. 10%, p = .05
- Need for comparison between FBT & CBT

What is FBT?

Early models of family therapy for eating disorders tended to be based on an "explanatory model" of the eating disorder



FBT

- Little support for the "psychosomatic family"
- Little support for the idea that certain family behaviors cause eating disorders
- But the idea that parents are significant contributors to the development of eating disorders continues to survive today

FBT

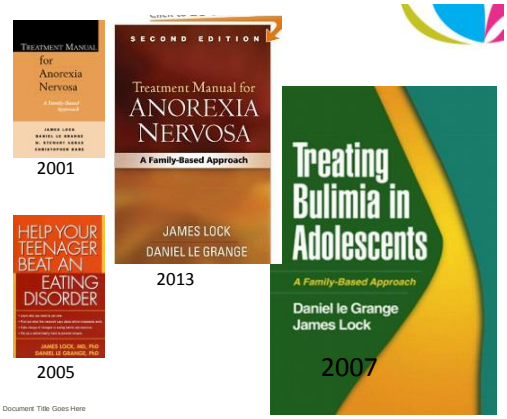
- One reason may be that clinicians often notice certain family patterns in families with an anorexic child—tempting to revert to causal explanation
  - Possible explanations:
    - Families in which a child has a life-threatening illness may tend to avoid conflict (irrespective of whether they did so prior to illness onset)
    - Parents may become "overprotective" when they are worried about their child's health (irrespective of their pre-eating disorder parenting style)

A Different Perspective

Models which focus on the etiology of the eating disorder are less helpful in guiding treatment than models which focus on **symptom maintenance**

Family Based Therapy

- The Family Treatment described **in this presentation** is an application of the approach developed at the Maudsley
- Manualized by James Lock (psychiatrist at Stanford University) and Daniel Le Grange (psychologist at University of Chicago)



Basic Principles of FBT

- The adolescent with AN is seen as ill and out of control around eating
- The adolescent is not viewed as being in control of her behavior; instead, **the eating disorder controls her behavior** (the illness is separated from the patient, or "externalized")
- The adolescent with AN needs the help of his or her parents to come back to health

Basic Principles of FBT

- Parents need to take charge of normalizing eating behaviors for their adolescent
- The therapist acknowledges that the parent's involvement in their adolescent's eating is out of sync with normal teenaged development
- The therapist clearly states that this involvement is **limited to the eating aspects** and **temporary** (the control will be returned back to the adolescent when her eating is normalized)

What about Motivation?

No assumption that the child/youth is motivated to recover

- Start treatment anyway—crisis, child needs to eat
- Food will improve thinking and motivation often follows

The focus remains on the symptoms until they are eliminated

- Normal adolescent development is seen as having been diverted by the presence of AN
- Fundamental work on adolescent or family issues (independence, conflicts ...) has to be deferred until the symptoms have been eliminated

The therapist is a consultant to the parents

- Therapist doesn't give specific solutions
- Reminds parents of their skills
- Parents figure out their own mutually agreeable solutions
  - problem-solving with the help of the therapist

Appropriate candidates for this therapy

- 18 years of age and younger
- Diagnosis of a restricting eating disorder
- Needs to gain weight
- Living at home with their *family* (all individuals who are living in the same household with the adolescent with the eating disorder)
- Family must be committed to the therapy and attend sessions reasonably frequently
- Weight at or above 80% SBW
- Parents able to tolerate working together to help their child
- Lack of extremely high levels of parental criticism

Differences from "treatment as usual"

- One "lead therapist", with other professionals (paediatrician, dietician, psychiatrist) as consultants to the lead therapist, and/or family
- Individual therapy not recommended in first Phase of treatment-deferred to late in treatment, if needed
- Therapist remains neutral as to underlying "cause" of the eating disorder

Differences from "treatment as usual"

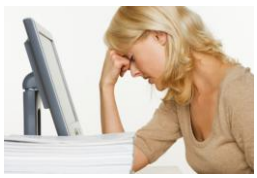
Therapist and members of the treatment team are not gentle/ reassuring

- Gravity and severity of the illness is emphasised
- Goal is to raise parental anxiety to help them initiate action to help their child

Differences from "treatment as usual"

- Therapist weighs patient at the start of each session and the weight is shared with patient and family, and graphed to measure progress
- Parents are actively involved in supporting their ill child to eat

Communication between members of the treatment team is crucial!



Differences from "treatment as usual"

The focus of therapy remains on the eating disorder symptoms until they have been eliminated

- Fundamental work on adolescent or family issues (independence, conflicts …) has to be deferred until the symptoms have been eliminated

Family Based Therapy

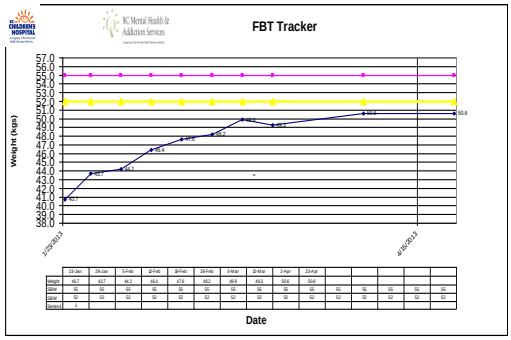
- Format - Outpatient basis, Three Phases
- 20 sessions over 6 months - 1year
- Phase 1: Sessions 1-10: Reestablishing healthy eating
- Phase 2: Sessions 11-16: Helping the adolescent eat on her own
- Phase 3: Sessions 17-20 : Family and adolescent developmental issues and termination

Session 1 - The first meeting with the family

- Of critical importance as it sets the tone for the whole first phase of therapy
- Three main goals:
  1) To engage the family in therapy
  2) To obtain a history of how the AN is affecting the family
  3) To obtain preliminary information about how the family functions

Session 1 Completed

1. Patient was weighed and Weight Graph is ready
2. Family is engaged in the process
3. The practice of separating the eating disorder from the patient has been started
4. The family has accepted the task of refeeding, knowing the seriousness of the situation
5. The family is prepared for next session's family meal



Session 2
The family meal

Session 2 - The Family Meal

Three major goals:

1. To continue the assessment of the family structure and its likely impact on the ability of the parents to successfully re-feed their daughter
2. To provide an opportunity for the parents to experience success in re-feeding their daughter
3. To assess the family process, specifically during eating

Session 2 - The Family Meal

- Goal is actually not for the family meal to go too smoothly—want to make sure the eating disorder is "active"—have parents feel they had the child eat just a little more than the ED wanted them to.
- Therapist may wish to have some "backup food" in case the family only brings very safe items or does not bring enough.

Session 2 — Completed

- The family is managing the adolescent's eating disorder.
- The parents helped the child eat one more bite than the eating disorder intended

Sessions 3-10 - The remainder of Phase 1

Interventions

1. Weighing the patient at the beginning of each session
2. Keep the focus of therapy on eating behaviors until they are normalized
3. Support parents to work as a team
4. Continue encouraging siblings to support the patient

Sessions 3-10 - The remainder of Phase 1

Interventions

5. Continue to modify parental criticism
6. Continue to distinguish the adolescent patient and her interests from those of AN
7. Close each session with a recounting of progress

Transition to Phase 2

- Guidelines signalling readiness for Phase II
  - Patient eats at regular intervals without excessive need for parental involvement
  - Parents report that they feel able to manage the illness
  - Patient's ED cognitions have improved

Transition to Phase 2

Sessions 11 – 16 (Approximately)

- Gradually return management of meals and snacks to the adolescent in an age and family appropriate manner
- Begin to explore the relationship between adolescent developmental issues and AN

Sessions 17-20 - Transition to Phase III

- Guidelines that usually signal readiness for beginning Phase III
  - Patient achieves a stable weight at 90-100% SBW
  - Self starvation has abated
  - Decision making around has been returned to the adolescent (in an age and family-appropriate manner)

Phase III

- Focus is "adolescent issues" — getting adolescent development back on track
- Normalizing these typical adolescent issues
- Model problem-solving of these types of issues with the family
- Remind them of generalizability of skills

Phase III

- Review issues like Perfectionism, Stress Management, Obsessive-Compulsive behaviours, rigidity, if needed
- Check on how the parents are doing as a couple
- Planning for future issues (e.g., leaving for University)
- Sessions are spaced 4-6 weeks apart

Summary and Conclusions

- FBT represents a new way of engaging families to truly be involved in helping their child or teen recover from AN
- It involves changes in how inter-disciplinary treatment teams work together to best serve their patients
- Emerging empirical support (and clinical enthusiasm!) for FBT places it at the forefront of treatments for adolescent AN

Other Therapies

- CBT-E (empirical support for adults)
- IPT (support in adults)
- RO-DBT (support in adults)
- Combinations of FBT and other modalities such as DBT, and EFFT—newer, don't yet have a body of research support
- Motivational Interviewing (support in adults)
- Adolescent focused therapy (AFT)-support in adolescents
- Bottom line—first focus must be on restoration of physical health via eating, regardless of treatment choice
  - FBT's strong focus on weight restoration makes it a first line treatment for child/adolescent outpatients

For More Training

- Certification in FBT is available through the Training Institute for Child and Adolescent Eating Disorders (train2treat4ed.com) and involves workshop attendance plus supervision.
- Other resources: Maudsleyparents.org
- Books for parents: *Help Your Teen Beat an Eating Disorder* (Locke and Le Grange); *Brave Girl Eating* (Harriet Brown).

Traditional Family Therapy in Eating Disorders

Karen Dixon MSW RSW

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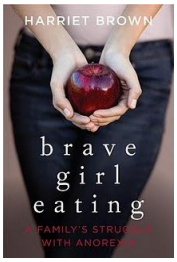

Family Therapy - Agenda

- How Family Therapy in Eating Disorders differs from Family Therapy in other areas
- Differences between Family Based Therapy and Traditional Family Therapy
- Therapist fears, pressures, self care
- Engagement
- Assessment
- Goal Setting
- Challenges – stuck families, stuck youth

Differences in Family Therapy with Eating Disorders

What you've learned in family therapy doesn't always apply

- Can't only work with identified family problems (won't resolve the ED)
- Don't get side-tracked with other family problems
- Face power & control of the eating disorder
- How does the eating disorder helps the child/youth cope with family issues?

Traditional, or Non-FBT Family Therapy - Preface

- Primary non-negotiable: the youth must eat
- Outpatient Family Based Therapy is largely goal directed to that end
- Family Based Therapy as first line of outpatient treatment unless not recommended.

When FBT is not Recommended at BCCH

- Family cannot commit to intensive supervision
- Non-compliance or treatment refusal
- Limited proficiency in English*
- Psychiatric diagnosis interferes with treatment
- Age of child
- Family conflict, parents unable to work together
- Less than 70% SBW
- Medically unstable
- Chronically suicidal
- Admitted to hospital
- More than 3 years duration of illness

How we help youth eat

- Meal support training for parents
- Dietician education and clinical support
- Inpatient structured meals
- Practice eating with family
- Naso-gastric feeding if needed
- BUT…

What then?

- The youth returns home to family and community
- How to help ensure ongoing eating success established in hospital once the youth goes home?

- Where traditional family therapy comes in

Differences between FBT and Traditional Family Therapy

- **Focus:** Narrower
- **Role of Therapist:** Consultant
- **Understanding of the Problem:** Family reorganized around illness
- **Goal:** Return to pre-morbid state

- **Focus:** Broader
- **Role of Therapist:** Collaborative Participant, Facilitator or Leader
- **Understanding of the Problem:** Family reorganized around illness, plus more**.**
- **Goal:** New normal

Which Model?

- Structural Family Therapy
- Systemic Family Therapy
- Narrative Family Therapy
- Satir Family Therapy
- Solution Focused Therapy
- Emotion Focused Family Therapy……

Clinicians in This Field May Fear:

- Safety (life-threatening, medical component)
- Having to have the answers
- The high profile family (high expectations)
- Stereotypes of families
- Long treatment, chronicity and relapse
- Maintaining hope and patience
- Effects of worn out families
- Working with unmotivated families

Engagement

1. Boundaries
2. Set the tone
3. Listen!
4. Validate
5. Balancing connection with individuals in the family
6. Emphasize a team approach
7. Provide information
8. Provide hope

Family Needs and the Therapeutic Alliance

1. Need to feel included
2. Need to feel safe
3. Need Information
4. Need help coping with the ill youth at home

Family Assessment

- Genogram
- Presenting Problem
- School & Peer Issues
- Abuse/Neglect
- Family experience of eating issues, health problems
- Willingness to be involved in treatment

Goal Setting

- Collaborative
- Look for common goals
- Special attention to sibling's needs
- Special attention to capacity of parents
- When to consider Separated Family therapy

Family Factors that are valuable in recovery:

- Having time
- Ability to focus effort
- Understanding of ED
- Ability to be organized
- Persistence
- Consistency
- Parental Unity
- Ability to be patient
- Tolerance of child's anger/ambivalence
- Non-blaming stance toward child for ED
- Willingness to let go of self-blame
- Put Recovery first
- Willingness to take control/supervise
- Ability to be compassionate
- Flexibility

Family Therapy

Help Parents To:

- Decrease parental self-blame
- Work together even if separated
- Understand the eating disorder & its functions
- Tolerate child/youth's ambivalence about change
- Deal with fear, worry and anxiety

Family Therapy

Help Parents To:

- Decrease power of eating disorder in family dynamics
- Decrease collusion and bargaining with eating disorder
- Find appropriate degree of limit setting
- Find appropriate degree of autonomy consistent with developmental level – food versus life

Family Therapy

Help Family To:

- Listen to each other, express emotions and gain mutual respect – including siblings
- Allow youth to speak up more directly about needs & feelings
- Tolerate increased voice of youth in recovery and intense emotions such as anger
- Connect more with each other – dyads
- Feel more confident/competent in their roles as parents

Family therapy challenges

When the youth is stuck:

- **Family is the resource!!!**
- Systemic thinking – if you change one part of the system, another part will change
- Partnerships
- Safety net

Family therapy challenges

- Tolerating the hard emotions (fear, anxiety, anger) and not letting this drive the relationship
- Build compassion – how difficult it is for the youth to change
- Support their competence
- See small steps of recovery
- Adjust expectations

Family therapy challenges

- Lack of therapeutic alliance
- Structural issues
- Cultural issues (interpreter??)
- Abuse/Neglect
- Sexual orientation
- Parent's own issues
- Sibling comparisons and sibling issues

Providing Meal Support for Youth

- Tom Bauslaugh M.A.
- Judy Lirenman RD
- Cathy DeCosse RN

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Resources

- tinyurl.com/eatingdisordersvideo
- tinyurl.com/eatingdisordersvideoBN
- tinyurl.com/eatingdisordersvideo5

A Personal Story

What we know

- Eating Disorders are serious
- Food is Medicine
- Youth must eat and gain/maintain a healthy weight
- Youth most often don't want to gain weight

How do we get them to eat?

- That's hard!
- The question implies a certain kind of answer

A Different Question

- What is making it difficult to eat?
- (almost) All youth eat something at some time and under some circumstances
  - What might be happening today that makes it more difficult?
  - What might make it easier?

Some Answers - Identity

- Identity – What would it mean if I eat?
  - Looked fat in the mirror today
  - Comparisons to others
  - If I eat it means I'm not sick
  - A real anorexic wouldn't eat this
  - If I give in I'm weak

Some Answers – Relationship and Support

- Relationship – Anger, communication, support, approach
  - How safe / supported you feel with the person
  - "F you" to parents
  - Posture / attitude
  - Trust
  - Safety

Some Answers - Motivation

- Motivation – The value of avoiding is more than the value of completing
  - Basketball season started without her
  - Saw someone thinner
  - Avoiding school / peers, etc.
  - Passes taken away

Traps Parent Fall Into – trying to Motivate (from Pat Roles MSW)

- Persuading: If only…. Please ….
- Begging: Do this for me…
- Guilt: I can't take anymore….
- Shocking: If you don't eat you'll die.
- Convincing: logical, educational.
- Threatening: If you don't eat we'll take away…
- Bribing: If you eat we will…
- Bargaining: I will do this if you at least…

Some Answers - Anxiety

- Stress / anxiety – something has happened to increase anxiety, lower mood
  - Fear foods on plate
  - Unhelpful comments – "You look healthy"
  - Arguments
  - Food changes
  - Threats
  - "A bad day" or stressful events
  - Nutrition labels

Youth Answers

- Youth focused on anxiety reduction through avoidance and control:
  - Less food
  - Safer food
  - Opt out
  - Measuring
  - Let youth control the food preparation / serving
  - Eat what we want

What is meal support?

- Meal support is a set of **strategies** that can help mealtimes go more smoothly, with less anxiety for youth and caregivers, as well as make it more likely that youth can eat the food necessary for them to be healthy.
- Meal support uses **structure and support** to lower anxiety and makes eating an easier choice.
- Meal support includes things that you can do **before, during and after meals.**

Meal Support

- We do not "make people eat", we support people in ways that make it easier for them to eat
  - These strategies do not require control or power (although that probably helps)
  - Collaboration usually helps
  - The support that we use is individual and will change over time

Components

- Before:
- Meal Planning
- Meal Preparation

- During:
- Supported Eating

- After:
- Post meal

Roles and Responsibilities

How can each person/ group build these ideas into their work?

School
Parents
Hospital
Clinicians

Meal Planning

Structure and Organization reduce anxiety

Ellyn Satter

Feeding without an ED	Feeding with an ED
Parent : What, Where and When	Parent: What, Where, When, **How Much**
Child: How Much	Child: Eat what your parents give you

Following a meal plan

- Ensures an appropriate amount of food is eaten
- Allows for appropriate corrections
- Helps lower anxiety in youth
- Helps caregivers stay organized – this is not easy
- Demonstrates understanding, competency, and confidence

Meal Planning

If it was an unplanned meal, I think your head just goes on and on. There's so many chances for your eating Disorder thoughts to spark up, It gives you an excuse to give yourself excuses about why you don't have to eat this, and why you should be doing something else, and being somewhere else...

Jessica

Meal Planning – How to

- Plan ahead
- Specify what, where, when, how much
- Give limited choices
  - some choice may lower anxiety
  - many choices may be overwhelming

Things to Consider

- Menu Items
- Challenge Foods
- Balance of individual and family needs

Meal Preparation

Choice and responsibility create stress

Choice is stressful

Having that internal struggle, like, my eating disorder wanted to be in there making sure that I was having the least amount of calories possible, and that the eating disorder was going to get its way. And just being provided with the permission to NOT do that and have my mom take that control away and make the meal for me actually provided me with a huge sense of relief. I felt like I was being given permission to NOT be involved in the process...and that helped with the internal struggle.

Frances

Choice is stressful

Having choice and responsibility is stressful!

The more important the choice, the more stressful it is.
Removing choice and responsibility is helpful

Youth in the kitchen

- Youth often want to be involved in:
  - Grocery shopping
  - Cooking
  - Serving
- This is usually due to anxiety driven by their eating disorder.
- Limiting choice and involvement can make it easier to eat

Avoid Measuring

Avoid measuring, counting, or weighing of food
- Youth will **always** challenge portions

- Learn and practice portions, so that you are confident with what you are doing
- Don't give control to the measuring cup!

Supported eating

Use a calm approach, distraction, and gentle encouragement to follow through with your plan

Build on success

- Youth usually make the decision about what they will eat before they start eating
  - Focus on structure, organization and planning
  - Don't second guess, negotiate, or discuss – stick with the plan!

What Youth Find Helpful

Staff	Family
-Keep the structure -remind of rules when necessary -Use distractions – games, trivia -Conversation	-eat together -play games -have a conversation -don't stare -no food talk

Structure and Supervision

- All meals and snacks may need to be supervised
- Eat at consistent, scheduled times
- Sit down and eat together
- Come prepared with something to talk about or do
- Have clear expectations and limits, including time limits (eg. 30 minutes)
- 100% completion: Their plate should look like yours

Don't look down!

When someone is doing something scary, don't remind them of that scary thing

Avoid sensitive topics
- Food
- Weight
- Appearance
- Other stressful topics – school, friends, recovery, etc.

Be respectful

•This is difficult for them, so we do things to make it easier:

•Follow the same rules
  •100% completion

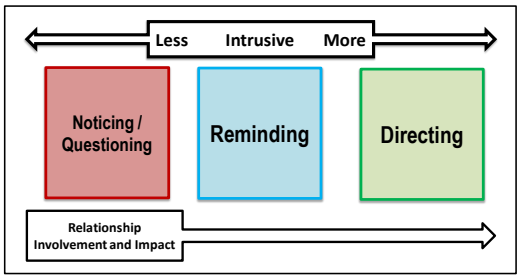
•Avoid diet and low fat foods
  - "sugar free"
  - "low fat"
  - "Lite or Light"
  - "calorie reduced"

•Be a Good role Model

•Do what you can to make things feel natural and normal

Other Strategies

- Address issues as they come: Hiding, smearing, crumbling, dropping, small bites, rituals, time length, getting up, etc
- Mechanical Eating
- Use gentle coaching and encouragement when needed
- Use a balanced and long term approach – this won't be solved in a day



Safety

- Not eating is a safety issue!
- **Energy in** cannot be less than **Energy Out**
  - If we can not increase the energy in, then we must reduce the energy out by restricting activity and increasing supervision
  - There is no safe amount of activity if weight is low or dropping
  - Physical safety trumps everything

Post Meal

Supervise and support youth after meals to help them manage feelings

A time for anxiety, guilt and pain

For many, after eating can be just as bad, or worse, than the eating itself

- anxiety
- guilt
- pain

The goal is to avoid developing negative behaviour patterns and give time for these feelings to naturally diminish

Compensatory behaviours

People look for ways to reduce anxiety

In eating disorders:

- Purging
- Exercise
- Self Harm

Supervision and support can prevent new, troublesome behaviours from emerging (or old troublesome behaviours from being used)

Limit access to the bathroom and be aware that this may be a difficult time

Energy Out

- Standing, pacing, secret exercise, perching, extra trips, doing chores, shopping, walking the dog, etc.
  - Activity is often a conscious effort to burn calories
  - Minimize activity through limits, supervision, and engagement

More Distraction and Supervision

- Family time
- homework time
- watch TV or a movie
- computer time
- Games
- etc.

Youth need supervision after meals until they are able to manage their own behaviour

What worked?

- Review (not necessarily with the youth)
  - what worked
  - what didn't
  - what to try next time

- Recovery is a long term project

What worked and what didn't?