A Holistic Approach to the Family-Based Treatment Model

in Children and Adolescents with Eating Disorders: The Role of the Registered Dietitian

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Eating disorders among children and adolescents have risen as a result of the change in lifestyle and increased stressors from the COVID-19 pandemic. With this rise, dietitians and treatment providers alike are treating more young clients. It is crucial to think ahead and anticipate how this will affect our children in the years to come, especially as they enter college and gain independence. Prior to the pandemic, I received many clients in my private nutrition practice who had participated in the Maudsley method and/or the family-based treatment (FBT) approach as a child or adolescent, yet had never worked with a registered dietitian (RD). In general, they presented at college age with a lot of distrust in authority figures and no idea of how to eat, despite having been weight-stable throughout high school. While these individuals had weight-restored, they had not fully recovered from their eating disorders, never having learned to trust their own bodies and/or feed themselves. As parents and practitioners, please ask yourselves what you can do differently going forward. This article encourages you to make full use of the multidisciplinary team in an effort to truly help the child and adolescent attain a healthy weight, a clear understanding of how to eat, skills for independent feeding and eating, and a solid foundation for their future.

The family model of treating eating disorders in adolescents originated as the Maudsley method after a 1987 randomized, controlled trial at the Maudsley Hospital in London. The foundation of this treatment model was then adapted and made more flexible by the research and clinical expertise of James Lock and Daniel Le Grange, who coined the model known today as FBT. The goal of this treatment is to have the family of the child suffering from an eating disorder, with the guidance and expertise of a trained therapist, take control of feeding their child to achieve a healthy weight. Lock and Le Grange did and do recognize the importance of a well-rounded treatment team incorporating multiple disciplines, such as the pediatric and adolescent physician, psychiatrist, and dietitian.[1] While this is noted in the FBT manual, a script or suggestions on how to use the whole team and/or specifically the RD have yet to be established. This article will augment the ongoing dialogue among professionals and families regarding the holistic approach to treating the whole person—specifically how the family, patient/client, and therapist can work synergistically with the RD and how they can support the FBT model and the recovery of children and adolescents. The following are suggestions and/or recommendations supported by over 20 years of clinical nutrition

IMAGE: iSTOCK

experience with clients diagnosed with eating disorders. Please use this article to ask more questions, to consider when to create a multidisciplinary team, and/or to follow along with the phases of treatment. This article speaks specifically to the FBT model; the expertise of the RD can be used in many ways, whether providing inpatient or outpatient nutrition services.

Parents Raise Nutrition Concerns When Asked to Refeed

Many parents come to the office of the RD and share that their own struggles with food are preventing them from knowing how to feed their teen. Not everyone has had an RD to teach them how to balance meals to prevent blood sugar fluctuations, how to determine what constitutes a snack, and/or what is enough to allow for refeeding and growth. Parents ask for basic education, such as "What are examples of carbohydrates, proteins, and fats?" "What is the difference between a serving and a portion?" and "What makes something like peanuts a protein versus a fat?" Other common nutrition questions parents ask are "How many calories does my child need?" "Should I just push sweets and 'junk food' to get my child to gain weight?" "Is it OK to serve clean, healthy food that I know my child will eat without causing a fuss?" and "Can I just sneak as much food in as possible?" All of these questions can be answered by the RD and will provide the foundation for parents to feed both themselves and their children. Working with the RD is an opportunity for the entire family to receive nutrition education and, hopefully, prevent future food and nutrition issues for all of its members.

The Three Phases of FBT

FBT is a three-phase treatment model, with parents serving as the most useful resource in their child's recovery from the eating disorder. Instead of being blamed for their child's ill health, the parents are supported, taught how to move forward on a timeline with specific roles for each individual (client, parent, and therapist), and equipped with strategies. Phase I is known as **Weight restoration**. This includes the initial evaluation with an FBT therapist and setting up treatment covering weeks one through 10. Phase II, formally known as **Returning control over eating to the adolescent**, lasts five weeks, from sessions 11 through 16. The child gains some freedoms during this phase and can begin to make decisions regarding eating and exercise. Finally, Phase III, **Establishing healthy adolescent identity**, addresses the issues of adolescence from sessions 17 through 20.[1,3]

When to Refer to the RD

In Phase I, according to Lock and Le Grange, "Parents are encouraged to work out for themselves the best way to promote weight gain and normalize eating in their child."[1] This is when parents and the therapist need to expand the treatment team to include the expertise of RDs, most specifically those who are certified eating disorder specialists (CEDS). The parents can set up an initial evaluation with the RD before starting the refeeding process. This should be done after session one with the "lead" FBT therapist. Parents and the RD will discuss the child's past and present state of health, including, but not limited to, laboratory values, blood pressure, menstruation, growth trends plotted on the growth

DIAGNOSING AVOIDANT/ RESTRICTIVE FOOD INTAKE DISORDER

A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
2. Significant nutritional deficiency.
3. Dependence on enteral feeding or oral nutritional supplements.
4. Marked interference with psychosocial functioning.

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.

D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

charts, and individual as well as family medical history as it relates to medical nutrition therapy (breast cancer, osteoporosis, diabetes, heart disease…). The CEDS RD, along with the pediatric and adolescent medical doctor, will collect all of this information to better determine the child's weight goals and the individualized nutrition goals with the parents. Next, the RD will gather information on the family's eating behaviors, the family's diet, and the child's diet. Together, the RD and parents will choose to create a meal program based on "exchanges," also known as nutrition equivalents, or a "meal structure," which outlines meal ideas and specific portions. The calorie range will take into consideration what the child had been consuming and the behaviors in which they had engaged, and whether overexercise, purging, and/or laxatives were active. The RD will determine an individualized calorie range to start the feeding process in order to help prevent electrolyte and metabolic disturbances known as "refeeding syndrome" or fluid overload.

Refeeding Syndrome

When an individual has experienced prolonged starvation, a sudden increase in nutrition can be fatal. Signs of refeeding and/or fluid overload may include, but are not limited to, low phosphorous, potassium, magnesium, and/or thiamine levels, which can result in cardiac arrhythmias, respiratory distress, ataxia, vertigo, and more. The RD and medical doctor (MD, preferably a CEDS) will be evaluating both electrolytes and vitamin levels, as well as weight, on a sometimes daily or weekly basis to ensure refeeding syndrome doesn't go unnoticed or untreated. If the parents, therapist, or RD observes a quick jump in weight gain, it is imperative that the child be medically evaluated and appropriately managed for refeeding syndrome. A child being refed is at higher risk for refeeding syndrome in the first two weeks of treatment.[2] The RD will help parents steadily increase their child's nutrition intake during this period of time (likely sessions two through five) and thereafter. It is a dance—an intimate collaboration between parents, the MD, and the RD.

Nutrition Education and Recommendations

Over the first few weeks, the parents will have formal check-ins with the RD, ranging from 15 minutes to an hour, to address and increase the meal plan, ask questions about the exchanges/meal structures, and assess the nutritional adequacy of what the family is feeding the child. The RD may educate parents on dietary calcium, low sex hormones, and osteoporosis, and then recommend ways to ensure adequate calcium intake. Other educational topics may include iron deficiency and treatment, ensuring adequate levels of vitamin D in the diet, and which strains of probiotics may be helpful for diarrhea, constipation, and the microbiome. Many individuals with eating disorders also experience irritable bowel syndrome, resulting from the brain-gut bidirectional connection—anxiety can cause gastrointestinal upset. When a child is reporting gastrointestinal pain and a change in bowel habits, it is important to acknowledge their observations and consider an evaluation with a doctor specializing in gastrointestinal health to rule out colon impaction or small intestine bacterial overgrowth. Meanwhile, the FBT therapist will address family roles in food shopping, meal preparation, feeding and eating behaviors, and mealtime discussions. The RD supports the lead FBT therapist's efforts to empower the parents to feed their child to weight-restore.

After the first month of treatment, the nutrition session frequency with the RD will likely vary in accordance with the child's weight gain and with the parents' confidence in employing

the exchanges or meal structure. At this point, the therapist and/or MD can refer the parents to see the RD on an as-needed basis.

"SHOULD I JUST PUSH SWEETS AND 'JUNK FOOD' TO GET MY CHILD TO GAIN WEIGHT?"

The RD and Phase II

It is time to resume nutrition sessions when the child is nearing the level of readiness for independent eating during Phase II, sessions 11 through 16. The child and parents would benefit from a family session with both the RD and the lead FBT therapist to assess the current feelings, thoughts, and behaviors around food, exercise, and body image. In this session, the family and team can together identify concrete goals for future nutrition sessions. Typically, the lead therapist and the RD determine what is psychologically appropriate for the child regarding nutrition education and empowerment. The RD may teach the child meal and snack exchanges, create a new meal structure (an outline of meals and snacks with approximate portions), arrange food or social meal exposures, or even join the child for a supported snack. The RD can educate them about how and why an "eating all foods" approach supports overall mental and physical wellness.

The RD and Phase III

The RD will help the client transition from an externally motivated nutrition plan to one that is internally regulated, using nutrition education, mindfulness, and, perhaps, intuition. Eventually, the child will progress from nutrition exchanges (nutritional equivalents) to a meal structure to a more internally focused format, engaging in mindful eating and, possibly, intuitive eating or integrated eating. The nutrition sessions in Phases II and III are similar to those that dietitians do with other outpatient clients. One can use a readily available script from publications such as *Winning the War Within: Nutrition Therapy for Clients with Eating Disorders*[4] or as guided by their CEDS supervisor. Phase III with the RD is essential for teaching the client/patient to be an independent feeder and eater in the present as well as the future.

Every treatment plan, including those that use the FBT model, should be individualized to meet the child and the family's emotional capabilities, physical health, and socioeconomic constraints. The above can serve as a conversation starter, as a consideration when creating a multidisciplinary team, or as a guide for following along with nutrition and FBT sessions.

One of the most important endeavors in finding a team to work holistically is the ability for everyone to respect one another and their roles, whether parent, child, FBT therapist, MD, or RD. Using the services of the RD will ease the burden of the parents and help ensure that the child learns to eat appropriately for life, not just for a short-term weight increase (Phase I). This is not a time to just "bulk up," but rather a time for parents to be empowered to nourish with food and love, soon to be followed by a time for the child to be nourished with food, love, and education. The RD hopes to shorten the eating disorder journey and to ensure that the child is provided with ample food and nutrition knowledge and skills sufficient to feed themselves well into their 20s and beyond. It is important to remember that FBT does not stop at Phase I, but continues on to Phases II and III with the work of the FBT therapist, the MD, and the RD. ◆

REFERENCES

1. Lock, J., & Le Grange, D. (2013). *Treatment manual for anorexia nervosa: A family-based approach* (2nd ed.). Guilford Press.

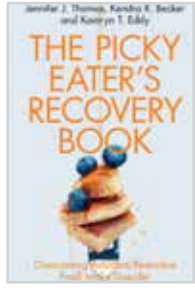
2. Persaud-Sharma, D., Saha, S., & Trippensee, A. W. *Refeeding Syndrome.* [Updated 2020 Nov 20]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK564513/

3. Lock, J., & Le Grange, D. *Family-based treatment of adolescent anorexia nervosa: The Maudsley approach.* http://www.maudsleyparents.org/whatismaudsley.html

4. Myers, E. S., & Caperton-Kilburn, C. (2020). *Winning the war within: Nutrition therapy for clients with eating disorders* (3rd ed.). Helm Publishing.

RECOMMENDED READING

The Inside Scoop on Eating Disorder Recovery: Advice from Two Therapists Who Have Been There
Colleen Reichmann & Jennifer Rollin, 2021



The Picky Eater's Recovery Book: Overcoming Avoidant/Restrictive Food Intake Disorder
Jennifer J. Thomas, Kendra R. Becker & Kamryn T. Eddy, 2021