# Family-based treatment for eating disorders: compassion and care through the storm of phase 1 Webinar Transcript

September 22, 2021

la-shell_johnson@med.unc.edu: Welcome and good evening. We are going to get ready to get started. But before we get started, I would like to point out a few things to note.

la-shell_johnson@med.unc.edu: All participants will be muted upon entry and videos turned off. Second, for technical assistance, we ask that you use the chat box, the Q and A box will only be used for question and answers which will be answered at the end of the webinar presentation today. You will also receive an email in approximately three months requesting feedback and impact on this presentation. Lastly, we ask that you visit www.ncedus.org/training to view other training opportunities that NCEED provides.

la-shell_johnson@med.unc.edu: I'd like to go ahead and introduce today's speaker.

la-shell_johnson@med.unc.edu: Today, we will hear from Dr. Stephanie Zerwas, a child clinical psychologist with expertise in eating disorder prevention and treatment. She's an Associate Professor at UNC Chapel Hill in the Department of Psychiatry and the former clinical director of the UNC Chapel Hill Center of Excellence for Eating Disorders.

la-shell_johnson@med.unc.edu: Her published research focused on dysregulated eating in childhood, psychiatric genetics, and longitudinal data analysis and defining eating disorders prodrome – early signs and symptoms that emerged before the onset of eating disorders that could assist in early screening and detection.

la-shell_johnson@med.unc.edu: In her current role as owner and founder of Flourish Chapel Hill, a private practice dedicated to teens and young adults facing eating disorders. She works closely with primary care providers and dietitians to provide evidence based therapy for anorexia nervosa, bulimia nervosa and binge eating disorder. She provides family-based therapy for eating disorders and helps families work towards a full recovery from the eating disorder. I will now turn things over to Dr. Stephanie Zerwas.

Stephanie Zerwas: Thank you so much La-Shell for that really nice introduction. I'm so grateful to be here this evening, and also to have you guys join you know.

Stephanie Zerwas: Often, often we think about our time is being incredibly precious, and that it just seems like we don't have enough time to do everything we want to do. So it's such an honor to have you join us here today and talk a little bit more about family based treatment for eating disorders.

Stephanie Zerwas: I titled this compassion and care through the storm of phase one, primarily because this first phase of family based treatment can be such a whirlwind for families.

Stephanie Zerwas: And, I really want to give you a sense of what this looks like in private practice, what this looks like in primary care settings, and, really provide an introduction today on how families can experience this time, and what we can do as providers to support them and support the teenager facing an eating disorder.

Stephanie Zerwas: So one of the goals that we will have today is to describe the three different phases of family-based therapy for eating disorders.

Stephanie Zerwas: We will be primarily talking about phase one today, and yet there are three different phases of family-based therapy and frequently. When we talk to people, they only hear about phase one. So it's important that we also really reflect on those other two phases, even though we're not going to do a deep dive today.

Stephanie Zerwas: I also want at the end of this session today for you to be able to assess whether a family is a good candidate for family-based therapy for eating disorders. Not all families want to go down this path, or are maybe the best fit for family-based therapy.

Stephanie Zerwas: The other thing that I'd like you to think about is maybe applying some principles of family-based therapy to your own cases, or to your own patients and really think about how could a family-based therapy helped a family that you might know either in your own personal life or in your clinical work.

Stephanie Zerwas: I also wanted to come together at the end and describe and think about self-compassion mindsets that could help both parents and teens with eating disorders, as they work towards normalizing this eating pattern.

Stephanie Zerwas: Frequently, we hear a lot of self-criticism and eating disorder treatment, especially from the patient struggling with the eating disorder. And we also can frequently hear self-criticism from parents who are blaming themselves for the situation, or blaming themselves that they're not able to help their kid in a way that they think they should be able to do so. So we'll talk a little bit more about how do we help people approach this with self-compassion and find ways to be better friends themselves through this process.

Stephanie Zerwas: So first question is why Family-based Therapy?

Stephanie Zerwas: Why include families at all in this treatment? And historically, parents were typically blamed for their children's illness and eating disorder treatment. I often see this when I talk to older psychiatrists, older therapists, about the work that I do. When I tell them I do family-based therapy for eating disorders, they sort of look at me quizzically and say like "what"? I've really never thought that we would include the families in treatment. There's often a bias and a way of looking at families and saying, "Man I think it's this person, or this teenager, this 14 year old struggling with an eating disorder, because look she's got this really enmeshed mother and the eating disorder was a way for her to reclaim control in the family system."

Stephanie Zerwas: You know that mom just seems like she's too invested in her kid's life. And maybe even more than a helicopter. And so, sometimes you'll hear people talk about parent-ectomy almost with kids who are struggling with eating disorders.

Stephanie Zerwas: One thing that we know for sure, is that when somebody is facing potentially a life threatening illness and a really bewildering illness. Oftentimes the parent that we see walking in our door, who is bringing their child to treatment and is curious about what they can do to help their teenager, they often look really anxious and sometimes they look really unmatched and over bearing and like really focused on details. Not because that was their baseline, but because they are responding to how bewildering and confusing and what a strange experience their family is going through.

Stephanie Zerwas: So, I think it's important for us to realize that we are often, when we're interviewing a family who is facing treatment and thinking about this new eating disorder diagnosis, we are often seeing them on one of their very worst days, and we are often seeing them when they're incredibly stressed out and worried. And so, sometimes we have to reserve our judgment about what this parent is like, or what the family is like until much later.

Stephanie Zerwas: So it just to go back to in 2010 the Academy for Eating Disorders position paper recommended unequivocally, that family should be included in treatment and that families are not to blame for the development of the eating disorder.

Stephanie Zerwas: Why FBT? And why, why do we recommend this as a first line treatment for teenagers, who are struggling? Um, number one it's an evidence based treatment. There's considerable evidence that this is a highly effective treatment for teenagers with eating disorders and I think one of the things for me personally and working with families.

Stephanie Zerwas: Is that it can also help avoid/foster an eating disorder identity. It's always wonderful when we can have a teenager who is able to stay at home in their family system and still be involved in other parts of their life that we're not stripping away all the other things that they're interested in their hobbies their piano lessons.

Stephanie Zerwas: Their participation in sports that we are allowing the patient with the eating disorder, not to only focus on the eating disorder, but also focus on other things that enrich their life and.

Stephanie Zerwas: Also, in addition to being evidence base and highly effective it's also way more cost effective for people to be treated on an outpatient basis rather than go to a more restrictive clinical unit like an intensive outpatient program or a partial hospitalization program or definitely you know, an inpatient or a residential program. So if we can work with families and give them much more cost effective options to help their child recover.

Stephanie Zerwas: It can be a really important outcome to think about how this is going to affect the family's finances and also allow them to provide long term support.

Stephanie Zerwas: So one question is, “Which eating disorders?” And we definitely have the most data on anorexia nervosa in teenagers, ARFID, as well as bulimia nervosa. And so in fit teenagers with Anorexia Nervosa, 49% of the patients were able to achieve a full remission 12 months later, and they were much less likely to be hospitalized than other treatment modalities that were delivered on an outpatient basis in bulimia nervosa. Thirty-nine to forty-four percent of patients are completely abstinent from binge eating and purging 6-12 months after the start of treatment.

Stephanie Zerwas: For avoidant restrictive food intake disorder, also known as ARFID. For those of you, not as familiar with ARFID, it's a newer diagnosis that where people struggle with taking in food that really doesn't fit a certain sensory pattern, or sometimes it might follow up on color lines or sometimes their food.

Stephanie Zerwas: Choices just get restricted to a specific kind of food. There are current ongoing studies being done with FBT right now, or Family-based Therapy, and it'll be really interesting to see if it's also effective in that disorder as well.

Stephanie Zerwas: So.

Stephanie Zerwas: The role of the family therapist is maybe a little bit different than in previous eating disorder treatment modalities that you've heard about with CBT or even in family systems work, the principles of FBT really includes separating the eating disorder from the child, and thinking, and thinking, and discussing with a family that they have a daughter or a son, who is facing an eating disorder and that the eating disorder is really driving a lot of the decisions that their teenager is making about food, and sometimes decisions they're making about how to spend their day. So it's really important in talking to families that we are trying to pull apart the kid that they knew before the eating disorder came into their life. And this sort of eating disorder voice or eating disorder preference, preferences that they've heard much later. It's really interesting sometimes to talk to families and talk to teenagers and say, “Hey, what when can we look back and think about when this came into your life. Because oftentimes it's maybe six months, seven months, even before they come in to their first session. And, they'll say things like, “listen before the eating disorder even started,  my daughter really loved ice cream and like we would have like a bowl of ice cream and share that and watch our favorite show at night.

Stephanie Zerwas: But when this eating disorder came into our life, all of a sudden that went away." So it's really important for us to think about like, how do we go back to that earlier stage and look at separating the eating disorder behavior from the child's own decisions and from their own desires. Because oftentimes they can feel very enmeshed and like overlapping. In my role as therapist I'll tell families I'm your coach here.

Stephanie Zerwas: The family is always the expert on their child they've been with their teenager their entire life, they have a long history together and they know what works and what doesn't work. They know how to motivate their child much better than I do.

Stephanie Zerwas: And I serve as coach and really talk about okay, this is what I've seen other families do. This is what I've seen work and not work here, here are some suggestions that I can make based on how I see this go and how the parents develop skills. And it's really important for families to know that they are being empowered to do what's in the best interest of their child throughout it.

Stephanie Zerwas: The power really lies with their decision making and it's important for the teenager who's facing the eating disorder also hear that.

Stephanie Zerwas: It's not you know, it's not up to me, not to the treatment team, not up to the therapist really their parents are the ones who are driving this and we're all here. You know, sometimes riding shotgun, sometimes in the backseat coaching them on how to get to the next phase.

Stephanie Zerwas: So, like I said before, Family-based Therapy (FBT) involves three different phases. In phase one we are charging the family with having full parental control and monitoring over the teenagers eating habits, exercise habits. And, depending on what compensatory behaviors are coming into the room that might mean having monitoring over bathroom habits or other sorts of ways that the teenagers spend their time throughout the day. Once in phase two, once we feel like those behaviors whether its food restriction or purging behaviors have totally been eradicated and are really not in a place where the teenagers struggling with them anymore. That is where we will start to have sort of a gradual return of control to the teenager and also allow a little bit more negotiation. Hey there you might have two different snacks. And, do you want to choose snack A or snack B? And then eventually allow them to really return back to the age appropriate choices that a teenager might make about what to have for a snack, or what to what they want for dinner that day.

Stephanie Zerwas: In Phase three fit it's really a way to go back into to revisit the developmental milestones and age appropriate independence that the team, the teenagers struggling with an eating disorder may have foreclosed on for a little bit while they're in the middle of Family-based Therapy.

Stephanie Zerwas: I have talked to teenagers who say, “Listen my driving lessons really got interrupted, and I just haven't been able to get my hours behind the wheel, because I was going to therapy sessions. We were always thinking about food, and now that I'm able to eat with regularity and I feel like this eating disorder is starting to be behind me, I can actually attend to these things again and do some of these age appropriate tasks that I haven't been able to do in the past.”

Stephanie Zerwas: So when is FBT not appropriate? Um, I think one of the things that's really important is to get an assessment from parents about their own eating patterns and whether they have also struggled with an eating disorder in the past. Often you know, sometimes asking them questions about their current eating disorder behavior in the home, I think, teenagers tend to be amazing hypocrisy detectors.

Stephanie Zerwas: And if they feel like they're being asked to do something that their parents are also struggling with, it can be really hard to empower the parents to make decisions for the teen who's facing an eating disorder.

Stephanie Zerwas: And also, if there's any sort of abuse happening at home, whether it's verbal, emotional, or physical abuse, then FBT really isn't appropriate and this can involve a lot of stress a lot of intense scenarios. And if the family, typically returns to abuse to manage their emotions during this time its FBT can just not go well at all. Um, the other thing that I also will ask families that I work with is, if there are any other insurmountable barriers that they might be experiencing that are keeping them from really committing to FBT at this stage in their life, a lot of families are in that sort of sandwich generation. And, you have parents who are caring both for their, their kids and then maybe also an elderly parent.

Stephanie Zerwas: Or if they're also struggling with different situations at work or other sorts of things that wouldn't allow them to press pause on these things and put their kid’s eating disorder first.

Stephanie Zerwas: And I really make sure to ask parents these questions in a non-judgmental way that this is asking a lot of their time, a lot of their commitment and it's good for them to have a real gut check with themselves, of how much can I show up for my teenager with FBT right now and do I have the bandwidth that will really allow me to be fully involved in family-based therapy.

**Commented [JL1]:** I think this is BT for Behavioral Therapist, but not sure. Please double check.

Stephanie Zerwas: And another thing FBT is just not appropriate at all, is if the teenager is really struggling with medical instability and is unable to be managed in outpatient care. This is where having a treatment team and having a close relationship with a pediatrician in town, who understands the medical complications of eating disorders, or a primary care doctor who knows these things it's, it's, critically important as therapists or psychologists of any different types to really be working closely with the medical team who can clear this teenager for FBT. Because it's, it can be important to catch those medical instabilities early and make sure that you're attending to them regularly.

Stephanie Zerwas: So one of the main principles of FBT is to normalize that eating pattern. And oftentimes whether the patient is struggling with binge eating or restrictive purely restrictive eating, we talk to patients and their families and they'll say, “Yeah we used to have breakfast together as a family and then that kind of fell off,” or “Yeah my kid always used to get a snack after school, but now it seems like that's not happening anymore.”

Stephanie Zerwas: And I talked about the importance of sort of anchoring that each day and having consistency with the eating pattern and how important that is in this first phase of treatment.

Stephanie Zerwas: Normalizing the eating pattern doesn't necessarily mean that the person who's struggling with an eating disorder is eating the same amount of food, as they did before.

Stephanie Zerwas: One of the other main goals of this first phase of treatment, is for folks especially who have like fallen off their growth chart and are in a weight suppressed state, is to also really focus on weight restoration throughout this phase.

Stephanie Zerwas: So, if anyone is malnourished before the start of their phase one, it's really important for us to work on restoring weight and getting back to where they before they were before, or where they would have been if they had continued on their growth curve. So it's important in this first phase to think about making sure that people are really going back to three meals a day, two to three snacks, and oftentimes that can be really scary to the person who's struggling with the eating disorder at this time.

Stephanie Zerwas: And sometimes I hear from people, listen I don't get it like, why are you focusing so much on food during this time. You know it doesn't really seem like this patient needs to focus on that, first, they need to change how they're thinking about things first and then it'll be easier for them to eat.

Stephanie Zerwas: And one of the things that we know from the Minnesota Starvation Experiment, and if you're interested in this study there's a much longer deep dive on the NCEED website, is that being in a sustained pattern of malnutrition, being in a sustained pattern where you're just not getting enough for being undernourished can increase food preoccupation. It can increase self-loathing or guilt about eating patterns, it can increase just sort of an obsession with food overall. And, so a lot of the things that we know from this study is that having the sustained period results can rid of the symptoms of eating disorder sometimes, or what looks like eating disorders to the outside world. So, it's critically important for us to reverse malnutrition and reverse this undernutrition that so many of our patients come in the door with. And if we reverse that, sometimes we often see dramatic changes in thinking and behaviors and obsessions that people have with food.

Stephanie Zerwas: Another question that I get from families frequently is, listen, I don't really know what my kid likes to eat anymore. You know when if I looked at the history here, you know she's 14 but if I think about it, like it was in seventh grade that she decided that she wanted to be a vegetarian or it was in eighth grade that she sort of up the ante and decided that she wanted to be vegan.

Stephanie Zerwas: And, it's important for us to really assess whether that was a moral judgment, or perhaps maybe was an emergence of the eating disorder that even started before anyone else detected it, or before it led to a rapid weight decline. And, so it's really important to use the family's experience to figure out the food preferences that you're seeing in the room. Is that due to truly a food preference or something that the teenagers cares about, or are we seeing the eating disorder manifested. And usually families and parents are the best reporters on what, what they think it's due to.

Stephanie Zerwas: The other thing I encourage families to look at is how much diet culture is coming into the home. And, so when we think about diet culture, we think about the ways that our culture, talks about dieting calories being good being bad tracking our calories throughout the day.

Stephanie Zerwas: And, and, oftentimes families when they start to see what diet culture is they kind of see it everywhere right, it can be that competition at work to see who you know drops the quarantine weight faster, or it can be that advertisement that they see at the grocery store that talks about guilt free chips right. And, so sometimes when parents become aware of their own examples of diet culture, they start to worry that oh my gosh, “Is this the reason my kid now has an eating disorder? Is it because they saw me change my diet or, or struggle with dieting, or how I talked about food or my body?” And, it's really important to let families know that diet culture, that home, did not cause the eating disorder.

Stephanie Zerwas: Truth be told, all of us are exposed to it all the time, and yet the recovery from an eating disorder often requires that they start to cultivate a new little microclimate at home that is nurturing and free of diet culture starts or comments. So, I'll give examples to families talking about appearance based comments at home really has to be sort of off limits and, sometimes, this is really hard to communicate to extended family or to older relatives.

Stephanie Zerwas: But within the like immediate family system, it's pretty easy to get everybody sort of on board with trying to be mindful of these sorts of comments. So appearance based comments like, “Did you see how much weight aunt Janet lost?” “Oh my gosh, doesn't she looks amazing she looks so healthy!”

Stephanie Zerwas: That could be comments about exercise and using exercise as a way to compensate for how much was eaten the day before. So I've got to start working out again, you know, so I can shed all these pandemic pounds.

Stephanie Zerwas: It could also be talk about food and talk about guilt related to food. So, I've been so bad today. Eat some bread, would be an example of diet culture types of top topics, or comments, and I think it can be hard sometimes to make these changes in the family and really approach these differences in how we're talking about food and eating in calories.

Stephanie Zerwas: And, so it's important to have some self-compassion that we're learning new ways of doing this and nobody's going to be perfect. To add, add it to start, even though they really want to like catch some of these comments early.

Stephanie Zerwas: The other thing that I talked about with the families that I work with, is that it's really important to be fully committed to FBT. And you can't really launch into FBT and then sort of change your mind midstream, right. It's sort of like trying to dive in and say I don't want to die, but I'm going to move back. It's where families, sometimes go from or feel really confused as when they try to both do FBT and something else, and everyone feels kind of confused.

Stephanie Zerwas: Frequently families all compare it to sleep training. Right, like if you're going to do the cried out method you guys stick with a cry it out method. And if you're gonna, you know, do co-sleeping, you've got to stick with co-sleeping. You can't like do cry it out, one day, and then back to co-sleeping.

Stephanie Zerwas: It's really important for families to sort of marshal all of their resources and really make a full commitment to starting the FTP process and really commit to it fully.

Stephanie Zerwas: Another note of caution here with families, is to catch expressed emotion. And, so express emotion has been shown and I'll talk about this later. But it's been shown to be one of the factors that it predicts that FBT isn't as successful. Um, and so sometimes families can feel sort of desperate and want to support their child in normalizing they're eating pattern, however, they can.

Stephanie Zerwas: And so it's really important to catch things like any sort of express guilt, "If you really love me, you would eat your dinner", or "can't you see how much money this costing us to take you to all these appointments", or shame "you know I must be the worst mom in the world if you're struggling with this." And these thoughts might be going on in parent's heads and yet having to take a beat and having a second and really not sharing these with the teenager. Bringing them to therapy, talking to the family therapist about these emotions, is a great outlet for it. But at the same time, the kid who's struggling with the eating disorder is probably only going to get more entrenched in their eating disorder behaviors. If they hear guilt and shame from their families and parents can also really struggle with anger during this process. How can you be so selfish or even sort of giving their kids the silent treatment?

Stephanie Zerwas: And sometimes also struggle with their own catastrophizing. Oh my gosh, this, this is never going to work! You're going to struggle with this forever.

Stephanie Zerwas: No, maybe, no one really recovers from eating disorder or engage in a lot of criticism. I don't know. I just don't think you're trying hard enough, and again it's totally natural to have these emotional responses to this process it's very, very, difficult and yet there it's important not to deliver this to the teenager who's struggling.

Stephanie Zerwas: One of the questions I get a lot from families is, “Why my child? Like what? Why? How do we get here? Why is it that our family is struggling with this? Is it because I had that diet? Is it because someone you know teased my child in fourth grade?” And, now we find ourselves here, and I will often use this analogy with families to talk about how to reduce some of the guilt that they're experiencing, that their kid is struggling in this way. And this comes from some genetic counseling literature and a book called, “How to talk with families about genetics and psychiatric illness.” We know that eating disorders run in families, due to genetic factors. And sometimes they use lots of different metaphors like, genes load the gun, and environment pulls the trigger and that, that definitely resonates with families. And, I also use this mental illness jar as a way to explain why some people are higher risk than others.

Stephanie Zerwas: So if we are thinking about how risk increases over time you've got these environmental factors over here, the little triangles, and you've also got genetic factors, and every one of us comes to the world, with different genetic risk factors for the development of eating disorders, some people have just a higher risk, and then other people have lower risk.

Stephanie Zerwas: But, it really requires a combination of both genetics and environmental factors all together, or that combined over time and sort of cross a specific threshold. And oftentimes that threshold is in puberty and around age you know, I think the peak age of risk for the development of anorexia nervosa is 13, the peak age of risk for bulimia, and an eating disorder is more in the 17 to 19 year old range.

Stephanie Zerwas: So, it does seem like is that when that threshold of risk then is crossed, but if you look at this it's really multifactorial. It's not that one specific risk factor led to the development of the eating disorder. It's really important to explain how all of these work together in concert. So, I will often tell families listen, this eating disorder your child's facing is not a choice or phase. It's not a cry for attention, it is not a bid to dominate or control family, they're feeling just as overwhelmed by the eating disorder as you are.

Stephanie Zerwas: And it's also not a condition that can be recovered from very quickly. It's it takes diligence, it takes persistence to recover, and yet there's an incredible amount of hope.

Stephanie Zerwas: And so, sometimes I'll draw out pictures for people that you know we sort of expect that they're recovering process is going to be very linear, and it's just going to be unidirectional.

Stephanie Zerwas: and yet, the reality is much more complicated and requires real patience, but also that sort of knowledge and that, that inner trust that, regardless of the curlicues along the way, that things are going to get better. We're going to find a way through this.

Stephanie Zerwas: One analogy that I frequently use with families when I'm talking to them at the beginning of this journey, is in some ways I'm asking them and charging them with running a very personalized treatment center.

Stephanie Zerwas: And I'll kind of ask them, okay, if I was talking to you about hiring a treatment center for your daughter, for your son, who would you want to hire for that work? What sort of qualities would you be looking for in the people who are providing that sort of support?

Stephanie Zerwas: And so, if you are looking for you know, patience, and compassion and resolve, you have to show up and be that employee that you would hire to take care of your child. And, so practically what this actually looks like, is families need to provide a lot of meal support in this first phase of FBT.

Stephanie Zerwas: The teenager doesn't participate in cooking. They're not making decisions about what to eat or what not to eat.

Stephanie Zerwas: Their caregivers are selecting food items, plating them, and providing each meal and snack, and also providing meals and snacks based on what they know that they're teenager's needs to eat. In order to recover, there's no negotiation on which foods are provided and sort of what amounts are provided from meal to meal. This is one of those situations where I talked about having sort of no half measures really going in and saying listen,

this eating disorder is taking over your life and I hear how hard it is for you to make decisions about what to eat, and what not to eat, and what you need.

Stephanie Zerwas: And, I'm taking that off of your shoulders as a teenager and putting it on my shoulders. I'm going to make these decisions for you, it's not for forever, but it's for this initial phase. Until you are able to normalize your pattern and the nuts and bolts of providing a meal support is really providing a quiet environment sometimes.

Stephanie Zerwas: You know, it can be tempting to say like okay, we're just gonna go out to our favorite restaurant and yet that's kind of an overwhelming environment, stimulating environment.

Stephanie Zerwas: Doing this at home, in a place that is quiet, and predictable, and familiar, is the best place to start. And, families are also encouraged to interrupt any food manipulation that they might see at the table. Sometimes our patients with eating serves will cut things into small pieces, or hide food. And the goal of meal support is really having 100% of food completion at each meal that the teen struggling with the eating disorder is able to really eat fully at each meal.

Stephanie Zerwas: We talked about the four C's of meal support, and the video that I'm linking to below is a really excellent video that gives an example of what this looks like from day to day. And I encourage you to check it out and watch it, but one of the four C's is just to remain calm throughout the process.

Stephanie Zerwas: That sometimes parents own anxiety, is she going to eat this? Is he going to eat? This can actually be kind of contagious. And so you want to appear calm throughout. Um, we also encourage families to be confident and really confident in the approach that they're trying, right.

Stephanie Zerwas: That you don't necessarily have to express that, that you're perfect at this and yet you have confidence that this is going to work, and you know what you're doing, and you know what they need in order to recover.

Stephanie Zerwas: The next C of meal support is being consistent. It's really important not to negotiate midway through. It can, the eating disorder voice can be so loud in some of our patients and they can be incredibly convincing about how this food is bad, or this isn't going to work and it's really critical to be as consistent as possible.

Stephanie Zerwas: The last C of meal support is to be compassionate. And compassion throughout this is so important. You can demonstrate empathy that you know that this is hard, that you realize that they're having to face their fears by eating foods that they might not have eaten in a long time. And yet you're here and going to provide consistency and boundaries and not diverged from this plan.

Stephanie Zerwas: So what are some of the meal support myths? I hear a lot is you know isn't this just force feeding your patient? Or, you know we, we can't force feed her back to health. And, I think an important thing for people to know is that when I talked to patients about this afterwards, they often described a great sense of relief. Because they had that somebody who was taking decisions about food off of their plate that they weren't able to have that support and not have to worry about this. And actually, have an ally in recovery and sort of fighting back at that, that, eating disorder voice.

Stephanie Zerwas: Another meal support myths, I hear frequently is, like if we're just focusing on meal support we're really not getting to the root of the problem and it's important for everyone to know that this fear of eating, this fear of weight gain is a really important root of the problem And, in some ways you're exposing people to their greatest fear at each meal, by providing consistent meal support.

Stephanie Zerwas: Another myth, I hear, is that this has to be done, completely alone or without like the rest of the family involved. That you have to sort of separate the team who's recovering, from the rest of the family. And as much as maybe going out to a restaurant, for the first time as you're starting to work on meal support isn't in everyone's best interest, it's really important to try to normalize the family dinner meal, or family lunch meal, or breakfast as much as possible. And be able to do this with other siblings, still be present with other family members to be present during the meal together and have meal adequate meal support.

Stephanie Zerwas: Another myth I hear sometimes is, that the child who's struggling with an eating disorder needs to hear why each food is necessary. And oftentimes logic about nutrition, logic about why they need each food, isn't really going to resonate during this time.

Stephanie Zerwas: So our ultimate goal for kids who are malnourished and undernourished is one to two pounds a week of weight restoration. Whereas an eating disorder therapist we're often providing blind weights, or sometimes open weights depending on the child's own response to their weight, I typically personally like to really normalize and allow the team to face their fears about these different numbers and have a shared understanding that we're working towards one to two pounds a week, and also allowing them to see what their weight change is over time, so they're not surprised later on in their journey.

Stephanie Zerwas: We're also encouraging families to monitor their children, after each meal, especially if there's any sort of concern about purging behavior. And, we know how much kids love to just like sort of go back to their room and be alone in their room. And, especially if parents have concerns about maybe hidden or covert exercise, purging, or some sort of like reassurance ritual that they're doing in the home. We will often address that through continuous monitoring.

Stephanie Zerwas: And another important part here is to also do some online monitoring as well. We know that teenagers can have a whole world on their phone and a whole world in social media.

Stephanie Zerwas: And so, it's important for families to sit down and really discuss and monitor. Whether there's maybe a YouTube fitness influencer that their teenagers following or tick tock influencers.

Stephanie Zerwas: Whether they're googling are looking for pro-anorexia or fat shaming accounts. There are lots of sort of what I eaten a day accounts that are on Instagram that people end up looking at a lot. And, it's important for us to look at that. The other thing I hear from my teenage clients is that sometimes they get really into taking photos and to monitor their progress, or really reassure themselves that they're not gaining weight too fast.

Stephanie Zerwas: And, so having an open dialogue about the use of social media and how their phone is intersecting with their eating disorder is also really important. I think the other thing to assess at the beginning of this journey and then also throughout, because it doesn't necessarily show up immediately and yet.

Stephanie Zerwas: It, it's important to have open lines of dialogue around obsessive compulsive disorder behaviors, sometimes as the eating disorder symptoms decline. We can also talk to teenagers who start to have a lot more intrusive thoughts that maybe the eating disorder kind of covered up, or we can see a lot of reassurance seeking, or verbal rituals or other physical ritual, so they start engaging with us during this process.

Stephanie Zerwas: And, it's also important to check in and discuss suicidal ideation or non-suicidal self-injury that might emerge during this process and make sure that we're assessing and keeping an eye out for it throughout.

Stephanie Zerwas: Sometimes, depending on symptoms that might also mean, including other members of the treatment team.

Stephanie Zerwas: And again in building a family team, I really encourage the providers to express compassion to the family, because they are facing something that is really scary. They're facing something that feels incredibly overwhelming, and they also kind of need a village to get through it. Too often families feel incredible amount of stigma that their child is struggling with an eating disorder and sometimes that leads to a lot of privacy and a lot of hiding the fact that they're facing this as a family.

Stephanie Zerwas: And so I encourage you to think and sort of imagine, who would I talk to, if we were facing a cancer diagnosis as a family.

Stephanie Zerwas: Who? Would there be a meal train? Would there be a casserole culture that you would sort of rely on? And we can also cultivate that sort of culture and communicate with other people and ask for their support throughout this process. We don't necessarily have to completely keep this private and a family secret.

Stephanie Zerwas: And frequently, it's important for all the family members to become experts at meal support as well. How, how do we especially the adults in the family, I should say the other teenagers other siblings in the family, we put them in a very separate role and ask them just to play a role of moral support throughout this process for the team who's recovering and yet, um other adults can play sort of this meal support role.

Stephanie Zerwas: So it's important for you know both parents to feel like they know what they're doing and can pass the baton one back to each other. Sometimes they'll need respite from, from meal support as well.

Stephanie Zerwas: And it's also really important for the treatment team to be compassionate with each other and have really clear communication.

Stephanie Zerwas: Where teams can get into trouble as if you know the pediatrician is saying one thing about what we expect the weight goals would be or what the progress should look like and the therapist is saying something else.

Stephanie Zerwas: And sometimes you know, there can be expressed emotion about treatment to each other, or even to the family, I don't know if this is really going to work. And they're also sort of struggling with their own sense of predictability here. And, so it's critically important to have direct communication about any sort of medical instability that the medical providers are seeing as well and thinking about a timeline and giving families a sense of what to expect.

Stephanie Zerwas: I've found in my own work that it's really important for families to sort of have a check in time maybe four or six weeks in. There's some research evidence that bears this out as well. That early weight gain in these first four to six weeks being able to start to approach these things with consistency and seeing a result in in terms of weight restoration helps predict whether fit is going to be successful or not. And, I definitely have talked to families who think okay, I can, I can hang in this.

Stephanie Zerwas: And I can learn all these new habits or change up my whole schedule in order to help family, my family get to this intermediate goal and then six weeks in we'll reassess and see if this is working, or we feel like we need more help along the way. But having a six week timeline tends to be a little more palatable to families. Rather than thinking okay, we're just going to do this and I don't know when it's going to end, or how long it's going to go on.

Stephanie Zerwas: And I wanted to make sure to include some articles that are reviews of a family based treatment for eating disorders, as well as some articles on moderators and mediators of remission.

Stephanie Zerwas: And then these books for families, I always recommend these resources. I usually start the first session, I'm giving him a list of books to check out, but then also making sure that they have online resources that are available to them.

Stephanie Zerwas: The YouTube videos by Eva Musby are great and give some concrete suggestions for meal support. And then the F.E.A.S.T. around the dinner table website is also a great source of support for families and allows them to talk to other families, who are also going through FBT and trying to support their teenager with an eating disorder.

Stephanie Zerwas: Alright, so we're going to stop there, and take any questions that people might have.

la-shell_johnson@med.unc.edu: Thank you so much Dr. Zerwas for this presentation. As a reminder, we will be sending out slides from today's presentation, along with the evaluation immediately following the webinar. We ask that you fill out the evaluation and send that back to us.

la-shell_johnson@med.unc.edu: This webinar's recording will be available on demand one week from today on our training Center. Any unanswered questions will be sent by myself, on behalf of Dr. Zerwas one week from today with those responses and any references included.

la-shell_johnson@med.unc.edu: Our first question asks, I am a nurse at a major children's hospital and recovered myself. I am finding it very difficult to get through to the hospitals' clinicians, medical doctors, and psychologists about the importance of family involvement and consider home based care not residential treatment. The outcomes of the children are very poor because of this. Any suggestions on how I can best educate and make positive changes? It is difficult to see the poor care they are receiving.

Stephanie Zerwas: I think there's so many different ways to motivate change in a hospital system like this. And, I think it obviously, I have a bias towards including families in treatment, especially because we know that, after you know stay in the hospital, families often are the, that first source of support and also are really hoping for answers on how to best support their loved one with the eating disorder. So I think relying on the research literature can be one way to try to shift the needle and change our hospital culture. I think the other thing is to really ask

about any barriers to doing this kind of work in a hospital setting. I know, everybody is facing increased barriers in including family members in hospital based treatment, due to COVID and really thinking about creative ways to facilitate online communication or even self-help guided family sessions can be really important. But it, it, it can be incredibly frustrating when you see people getting substandard care and yet moving the needle and having sort of small incremental goals change the culture in a hospital based system might be the way to go.

Stephanie Zerwas: So maybe even just starting with a you know, an added page the website that provides some of these things and empowering parents to ask questions of the staff and why they, they might be excluded from, from the hospital based care.

la-shell_johnson@med.unc.edu: Thank you so much that Dr. Zerwas. Our next question is a variation for FBT for families with high EE, is separated FBT, but then is the child still exposed to the same high EE at home? I've never been sure why even separated FBT is a good idea for families.

Stephanie Zerwas: That's an excellent question, I think one of the things I struggle with when there is high expressed emotion in session is that sort of dual communication to the child that, hey I'm empowering your family to take on this role and re-feed you. But also I'm changing their behavior and criticizing them over here on this side of the coin and so.

Stephanie Zerwas: I think from my point of view, one of the purpose says, of having separated FBT is to challenge how the family is communicating with their parents or communicating with their child. But doing it in a place where you're not necessarily undercutting their authority and so that's.

Stephanie Zerwas: That's a, that is a complicated dance for sure. But, often I find that families with high express emotion, if we do some kind of role play and I sort of put them back in the perspective of the kid who's receiving the high expressed emotion. They're able to develop empathy yeah, when you said that then when you guilt me about it, like all I wanted to do was rebel against you, it didn't motivate me, we weren't moving in the same direction.

Stephanie Zerwas: So I find that role plays are really helpful to get this message across. I find that helping them think about other ways to tolerate their distress and maybe hold their

tongue and without sharing the expressed emotion with their child can be really helpful and having other skills in the room.

Stephanie Zerwas: But I think that the separated pieces, just so that you're not undercutting that their authority and the people who are in charge of the repeating process.

la-shell_johnson@med.unc.edu: Thank you so much, Dr. Zerwas. So we have three more questions um, but I know we just ended at time. So what I'm going to say is, we will have Dr. Zerwas take her time to address these three questions and you'll receive those responses via email. Once again, I want to thank you all for joining tonight. As always, thank you once again for your time and for such a great presentation.

la-shell_johnson@med.unc.edu: Thank you once again, and please visit the NCEED website for other training opportunities @www.nceedus.org/training. Thank you so much.