ABSTRACT

Kids do not magically stop being their parents’ kids when they turn 18 years old. Nor does that birthday change the fact that eating disorders are biologically based illnesses severely impairing one’s ability to feed themselves due to the impact of malnourishment on the brain. Parents shouldn’t be expected to not worry, not get involved and not try to secure effective treatment for their sick child with a life-threatening illness because that child is now considered by law, an adult. Family-Based Treatment (FBT; Lock et al., 2001) has been shown to be effective in the treatment of adolescents with Anorexia Nervosa through the age of 18 years old (Lock et al., 2010). With the third stage of adolescence going into the early to mid 20’s and the scientific data further supporting this relative to brain development (CITIE), we are left to wonder about what this cohort of adolescents? The FBT outcome data, combined with the difference in the drop-out rates between FBT and individual therapy with adults (Lock et al., 2005), refutes among adults in individual therapy, (Halmi et al., 2005), the psychiatric and medical complications of the illness, and continued financial support and involvement these families led us to question how we could extend the success of therapy, (Halmi et al., 2005), the psychiatric and medical complications of the illness, and continued financial support and involvement these families led us to question how we could extend the success of therapy, (Halmi et al., 2005), of FBT and experience more ambivalence about their direct involvement with the food with the remission of acute psychiatric or medical symptomatology. Patients may re-engage in developmental tasks sooner than those in early/middle adolescents (i.e. returning to college once Phase 1 goals met) and require less structure for managing food due to absence of Phase 2 interventions. Participation of Adult Day Treatment Program requires meal plan. Young adults who experience a co-morbid mood disorder may be unable to make appropriate choices as a result once weight restored yet eat appropriately if decision-making is minimal.

MODELS OF FAMILY INVOLVEMENT

I. FBT-Y

- Parents’ role similar to that described in FBT manual.
- Play direct role with the food and management of behaviors (ie PCOs/stricts around bathroom use after mealtimes, etc.).
- Deviate from manual by often involving nutritionist and meal plan/meal cards which parent implements with individual variations on degree of specific information about food
- May involve collaboration in Phase 1 if supports treatment goals.

Rationale for adaptations:
- Parents may be more reluctant to reinstate higher density and/or fear foods given age than parents of younger adolescents.
- Families may not complete all the three phases of FBT and experience more ambivalence about their direct involvement with the food with the remission of acute psychiatric or medical symptomatology.
- Patients may re-engage in developmental tasks sooner than those in early/middle adolescents (i.e. returning to college once Phase 1 goals met) and require less structure for managing food due to absence of Phase 2 interventions.
- Participation of Adult Day Treatment Program requires meal plan.
- Young adults who experience a co-morbid mood disorder may be unable to make appropriate choices as a result once weight restored yet eat appropriately if decision-making is minimal.

II. Parental Involvement

This model involves a range of interventions that may or may not involve involvement with food/monitoring of behaviors and can include some or all components of this model. The specifics are often determined by the clinical team after the assessment and adapted relative to the phase of treatment. Variables considered for these decisions often include:
- Medical stability
- Length of illness
- Presence of co-morbidities
- Patient’s motivation/insight about treatment goals
- Family’s willingness/ability to engage in treatment process
- Previous treatment failure
- Living arrangement of patient and parents
- Ability to manage meal planning/intake needs relative to Adult Day Treatment expectations and goals

Interventions:
- Coaching parents and patients on emotion regulation and interpersonal effectiveness skills around illness/treatment and adolescent developmental issues.
- Identifying ways that parents can increase accountability/compliance outside of treatment hours.
- Involving parents in medical appointments due to brain malnourishment and inability to grasp acute and chronic medical consequences of their illnesses.
- Meetings with therapist on team without patient for psychoeducation, support and skills coaching relative to the illness.
- Providing emotional support/accountability/distruction/assistance with food secondary to patient’s treatment goals of identifying such needs and using skills to manage them to prevent behaviors.

Rationales for adaptations:
- Family involvement adjunct, but not primary intervention, as patient able to utilize treatment interventions in Adult Treatment Programming effectively and meet treatment goals without FBT-Y.
- High expressed emotion within family may not be effective for direct involvement with food/behavior until system has received adequate skills coaching to do so.
- Co-morbidities warrant additional interventions.

III. Parent Contracts

- Intervention based on reinforcement of parents’ role in their child’s safety and well-being giving lethality of the illness, judgment/making-decision-making ability due to ED and adolescent brain development despite legally identified as adult.
- Created by parents with psychoeducation/consultation from FBT therapist to identify criteria for young adult to re-engage in age-appropriate activities once stabilized (i.e. going away to college, driving car which is owned and insured by parents, etc.)
- Involves empowering parents to think about their needs/limits/parameters for their child and reinforcing their validity/appropriateness relative to impact of the illness.
- Functions to assist patients in reinforcement of mindset that ED behaviors as “non-negotiable” that occurs throughout FBT.
- Provides directives for parents should urges increase and/or motivation begin to decrease if contract around ability to engage in developmental tasks (“I want to / I want to weigh”) and, at the same time, I want to stay at school” which may reinforce use of compliance as both cannot co-exist given objective data monitored per contract.

CONCLUSIONS

Parents continue to be their child’s parents when they turn 18 years old and anorexia nervosa continues to be a life-threatening illness with irreversible medical consequences, psychiatric impairments and a poor prognosis if not treated aggressively. Given what we know from the adolescent research with FBT, the impact of the disorders on the brain and the fact that they love their children no differently than they had more legal rights to their care, parents should be empowered, educated and included in the treatment of their 18-25 year old children.

REFERENCES


EXAMPLE OF PARENT CONTRACT CREATED BY PARENTS & FBT THERAPIST

Contract utilized to support family in making decisions around sending young adult away for college:
- X has demonstrated radical acceptance of not having ED behaviors possibility of continued cognitions and urges (which is measured/recorded by items below).
- X must demonstrate ability to stay within weight range for minimum of 6 months post-treatment.
- X must require financial support from family to cover transportation and housing.
- X must be able to attend school full-time.
- X must not be able to continue to access food related to food and/or otherwise in a particular moment/in general, she/he will communicate this with parents (with parents’ agreement to see this as skillful vs. indication of not being able to go to school unless supports occur).
- If weight goes out of range, X will work with therapist to identify plan for prompt return to appropriate range and share plan with parents.
- X will continue to demonstrate responsibility/compliance with medication and treatment expectations.

Contract put in place when agreed upon by family, team, patient for plan to start/return to college away from home/winning stabilization of ED:
- X agrees to sign relevant releases to allow parents access to young adult’s medical information. All efforts will be taken to maintain X’s confidentiality w/ therapist unless pertinent to significant medical or psychiatric risk.
- X agrees to share meal plan and/or support related to food and/or otherwise in a particular moment/in general, she/he will communicate this with parents (with parents’ agreement to see this as skillful vs. indication of not being able to go to school unless supports occur).
- If weight goes out of range, X will work with therapist to identify plan for prompt return to appropriate range and share plan with parents.
- X will continue to demonstrate responsibility/compliance with medication and treatment expectations.

Contrary to research, please note that coming up with a plan for a 18 year old may involve different steps than we had more legal rights to their care, and developing an individualized plan based on the child’s needs.

WHAT WHEN A CHILD TURNS 18 YEARS OLD, ARE PARENTS SUPPOSED TO STAND BACK AND WATCH THIS ILLNESS POTENTIALLY KILL THEIR CHILD BECAUSE SHE/HE IS NOW AN “ADULT?”

Through a multidisciplinary approach that involves similarities and differences from the traditional FBT model, this poster highlights two different models for actively involving the parents of young adults in treatment as well as a specific type of parent coaching that simultaneously supports treatment goals and adolescent developmental issues when appropriate.