VIBES: EARLY INTERVENTION IN ADOLESCENT ANOREXIA NERVOSA

PART OF K-EET

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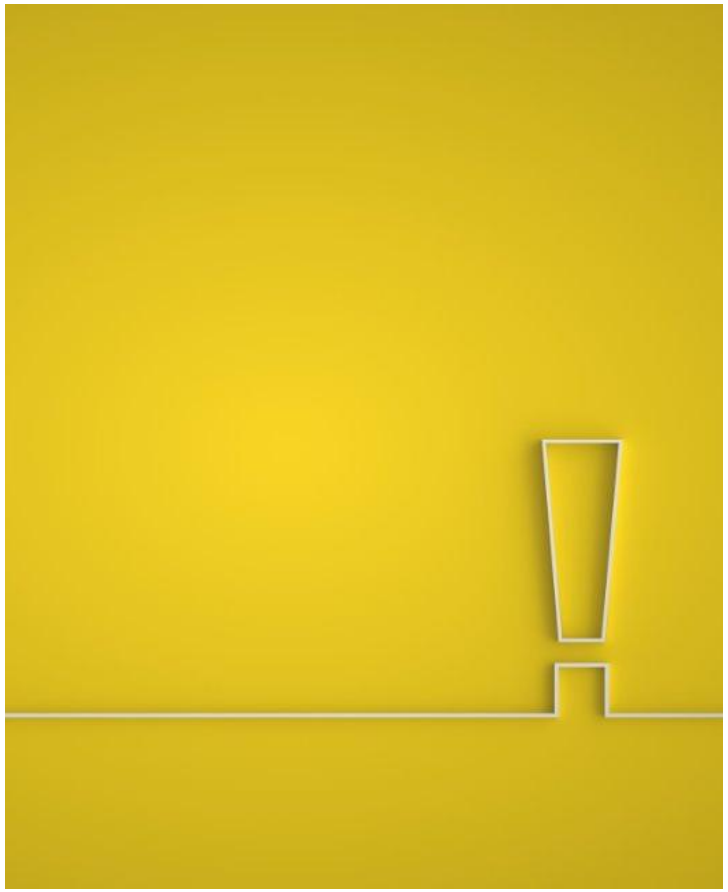
WITH HELP FROM ANJA, SABRINA, SUZANNE, JANNEKE, SABINE AND LIZA

WORKSHOP PLAN

- Short introduction of context
- Set up pilot
- Assessment specifics
- Treatment specifics

INTRODUCTION



2015: child & adol. psychiatry from healthcare to ‘welfare’, result: complete chaos

2019: K-EET is founded (https://kenniscentrum-kjp.nl/keet/); a national program to improve the care for youngsters with Eds

Early identification of AN, followed by efficient referral to appropriate care, is essential to promote a rapid and effective recovery process, ultimately leading to better outcomes and reduced societal costs.

2021: VIBES becomes part of this program

K-EET 'S MISSION

Children and adolescents with an eating disorder - or a vulnerability to it - deserve earlier recognition of their problem, better understanding and more effective treatment.

This is because early recognition and treatment leads to less suffering, fewer seriously ill children and adolescents and lower social costs.

Moreover, K-EET's mission is that no more children die as a result of an eating disorder.

VIBES?

VIBES: a novel approach to the treatment of AN in children and adolescents with early, first-episode illness to achieve rapid recovery and prevent the development of lifelong consequences of the illness

Stems from the development of F.R.E.E.D. (Austin et al, 2021), a CBT-E type treatment for emerging adults with AN who have been ill for less than 3 years

We have translated this approach to suit a younger age, based on FBT

PILOT

A short intervention early in the illness process

Coaching parents to regain control over their child with (emerging) AN

- Inclusion criteria
  - **Pedagogically strong parents**
  - ≤17 yrs, but developmental stage more important
  - Symptoms started <6-9 mnths before referral
  - No co-morbidity in the foreground
  - Treatment naive (except pediatrician)

PILOT

- Assessment within 2 weeks of referral
- Aims: anorexia nervosa? Test suitability, parental competence?
- Start treatment within 2 weeks after assessment
- Homework!
- Psychoeducation!

BEFORE ASSESSMENT

- SCREENING/CONSULT REFERRER
- QUESTIONNAIRES:
  - CHILD:
    - CHILD EDE-Q
    - YSR
  - PARENTS:
    - CBCL
    - CASK
    - GENERAL QUESTIONNAIRE
- OUTCOME QUESTIONNAIRES?
- SHORT MULTIDISCIPLINARY CONSULTATION BEFORE ASSESSMENT

ASSESSMENT

- 2 Sessions, 90 min each:
  - VERBAL: experienced psychiatrist/psychologist & family worker
  - NONVERBAL: family taxation

FIRST SESSION

- Content?
  - Symptoms
  - Approach parents? (This also allows you to assess pedagogical skills)
  - Comorbidity
  - Psycho-education
  - Holistic approach

- Timing?
  - <2 weeks of referral
  - Personnel: experienced psychiatrist/psychologist & family worker (future therapist)
  - 90 minutes
  - Anorexia nervosa? Inclusion criteria met? No interfering issues?

BUT ALSO….

YOU CAN DO IT!

- It is important to give parents a boost! At the start and through all the sessions, you want them to walk away feeling competent!
- Give parents the feedback they are fit for VIBES, because we truly think they are and can do it!
- Let parents realize they are pedagogically competent and should be proud about themselves.
- Always feed back the positive things you have seen during sessions.
- Positively reinforce their early signalling and search for help.
- Acknowledge parents about issues they find stressfull.
- Ask about problems they cope with in a good way.
- We are in it together!

AND...

EXPECTATIONS

- The family is immediately set to work, therapists coach but do not take over.
- VIBES? Fast start, intensive work, knowledge and tools! From the start we tell them we will help normalize the eating pattern.
- Set limits from the start: sessions and contentwise.
- Underlying problems/comorbidity issues will be addressed in a later stage, after we finish VIBES.
- Keep the problem small and simple, both in the assessment and in the treatment phase. Decide what you won't ask about!!
- It can be helpful to explain that we will evaluate at the end whether more help is needed, there are 2 sides to this:
  - The family may have the feeling they will be thrown in the deep at the end, and by addressing this at the beginning you can relieve this feeling.
  - Alternatively, you can choose not to do this and thereby underlining the feeling of competence of the parents.

FAMILY ASSESSMENT

- <2 weeks after first assessment interview
- Observation of family cooperation and limitsetting
- Do they recognize what the therapist observed? Same at home? Which qualities helped or hindered?

TREATMENT

TREATMENT

- Within 2 weeks of 2nd assessment, both parents(!)
- Sessions of 60 min, 5 sessions in total, by experienced psychologists/psychiatrists i.c.w. other professionals
- Flexible composition during sessions and time between sessions, possibly split up, do what is needed
- The intervention has a coaching approach

FOLLOW UP

- Review 2.5 months after the last treatment to see where the family stands and whether any follow-up treatment is needed and if so which one
- Take stock of whether or not VIBES has caused a decrease in eating disorder symptoms
- Treatment needed for other symptoms, underlying problems?

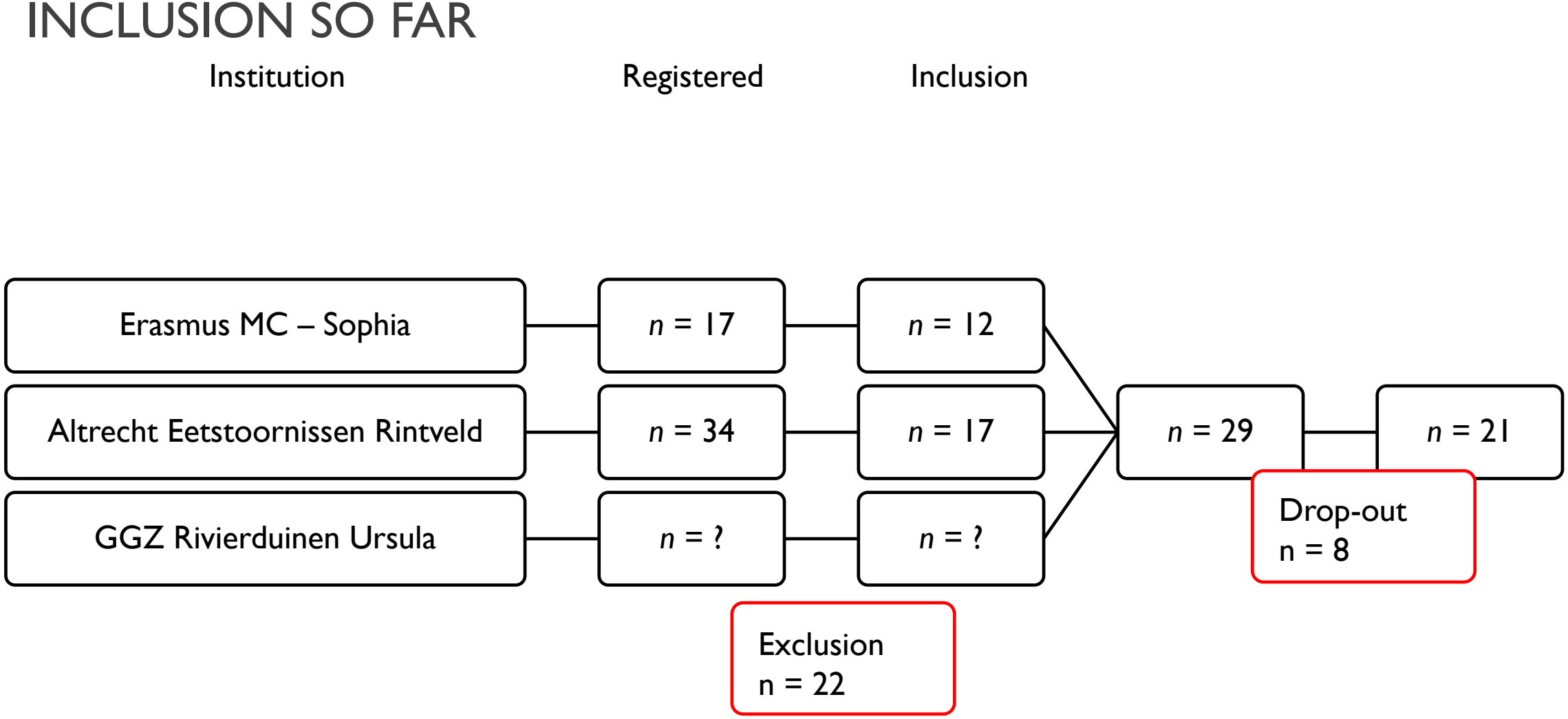
TREATMENT-TOPICS

- Pointing out information sources (internet, youtube, books)
- Information/pyscho-education about eating disorders including externalizing the eating disorder
- Explaining rationale for change, first eat then talk, parents must take the lead, focusing on restoring autonomy to the young person
- Step by step, pace adapted to child's anxiety
- Dealing with anxiety
- Consistency killers

INTERVISION

- Both internally and externally
- Discuss:
- Progress and any stumbling blocks
- How do you make sure you stay within the intended number of sessions?
- Things that stand out?

INCLUSION SO FAR



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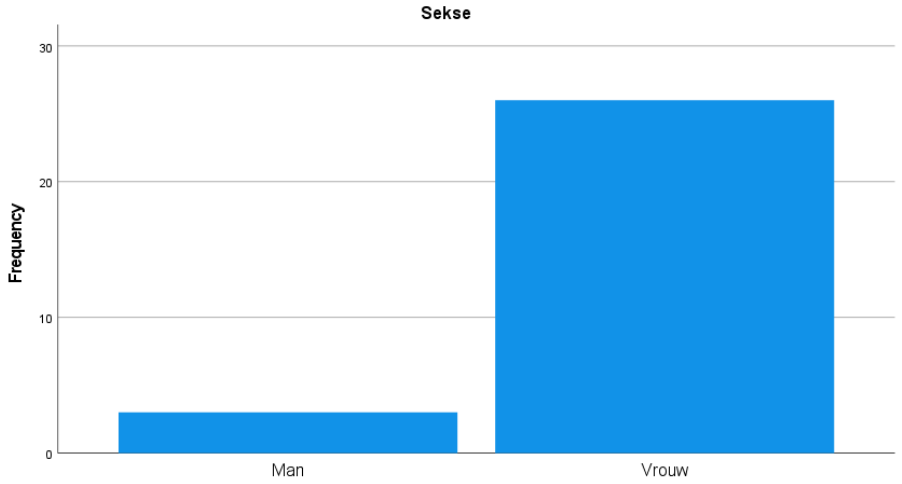

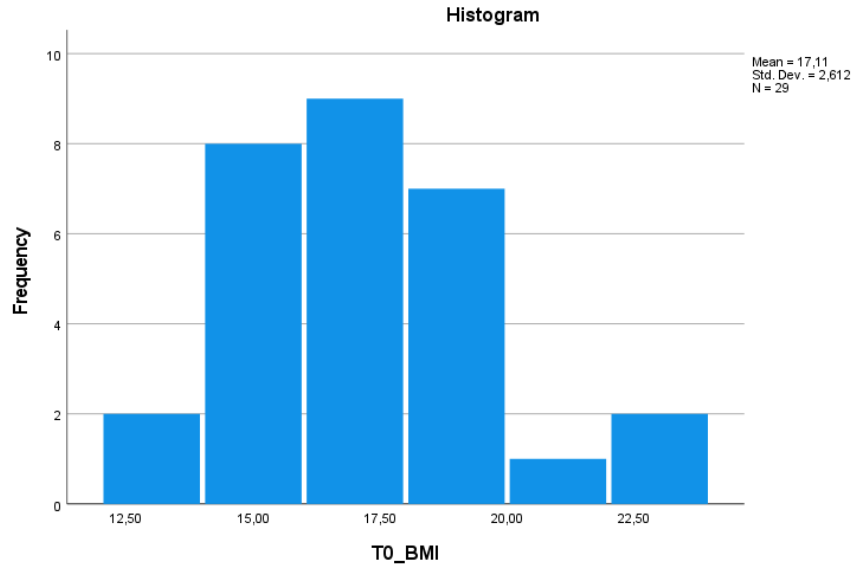

T0_Sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Man	3	10,3	10,3	10,3
	Vrouw	26	89,7	89,7	100,0
	Total	29	100,0	100,0	

Age

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
T0_Leeftijd_jaren	29	10,67	17,17	15,1408	1,53014
Valid N (listwise)	29				

BMI

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
T0_BMI	29	12.10	23.50	17.1062	2.61241
Valid N (listwise)	29				

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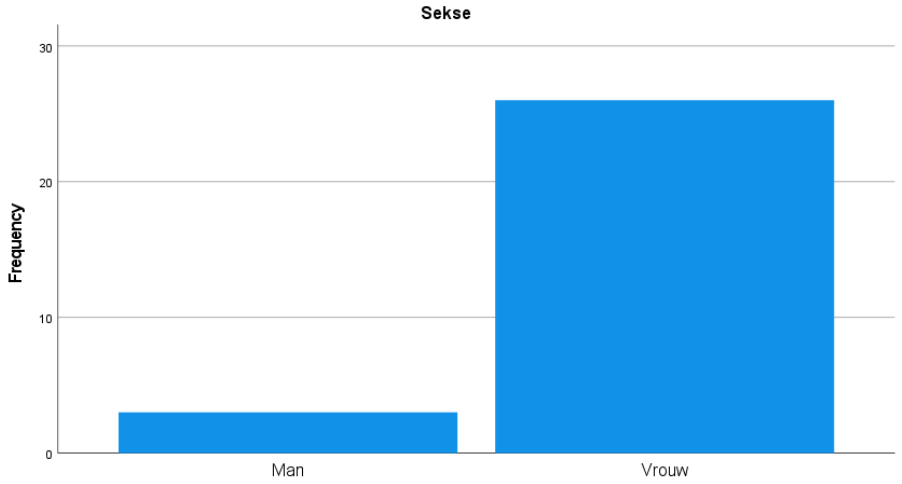

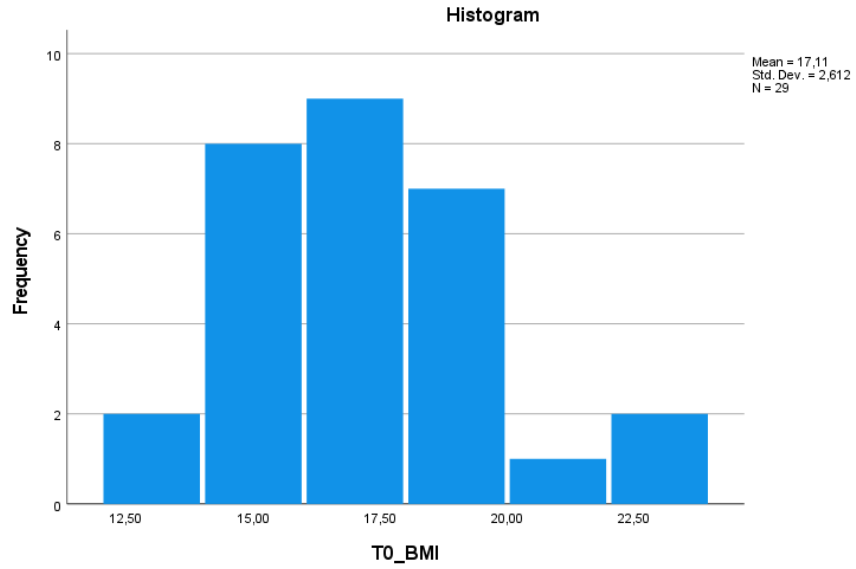

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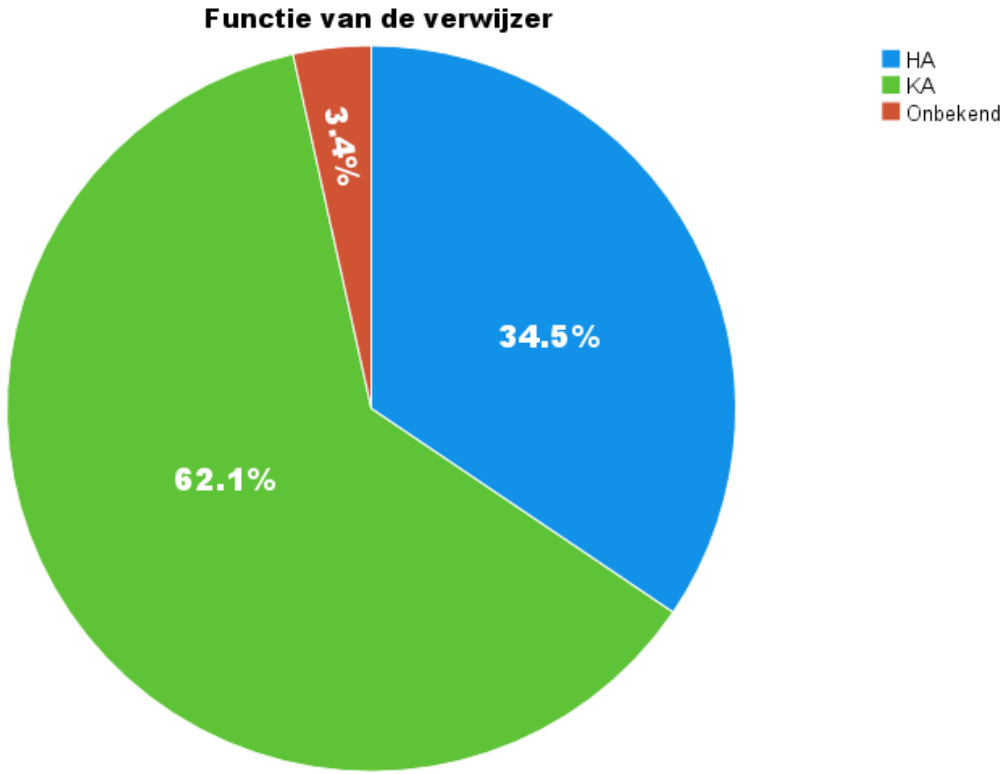
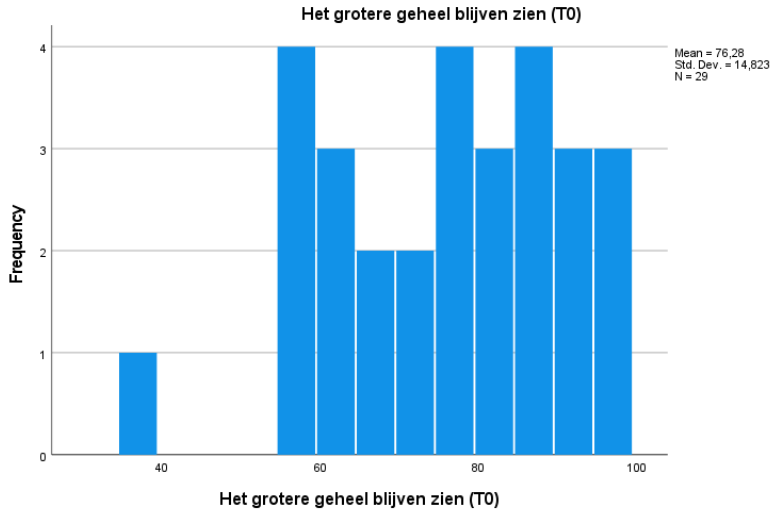
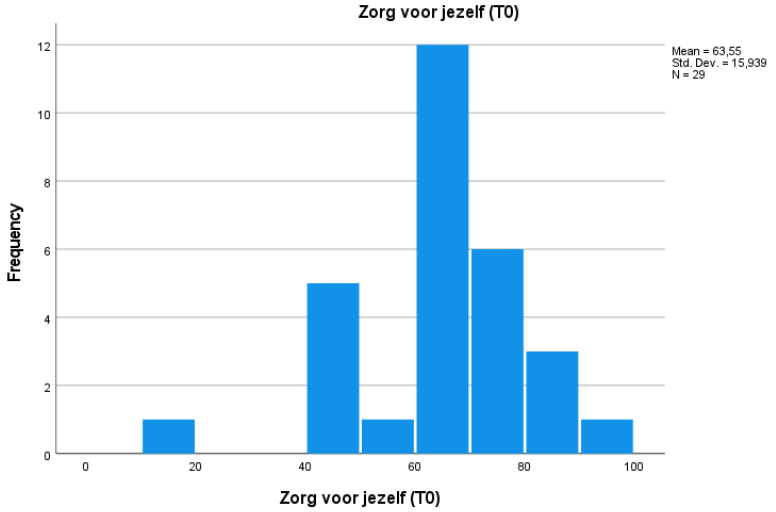
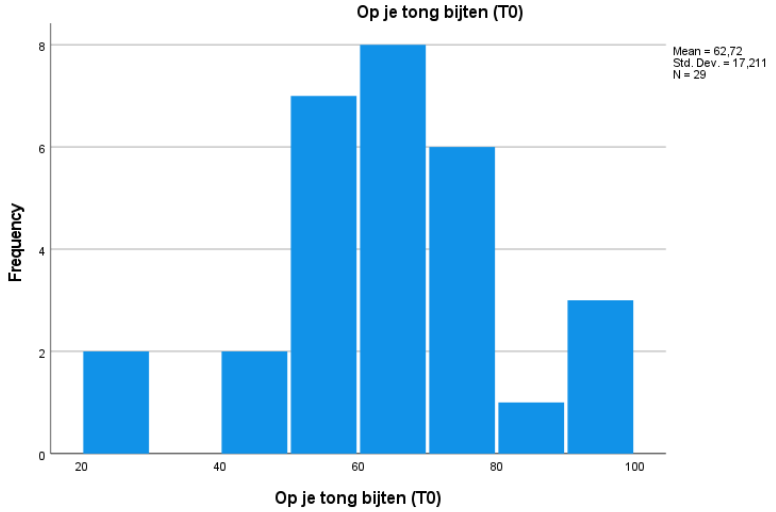
REFERRER

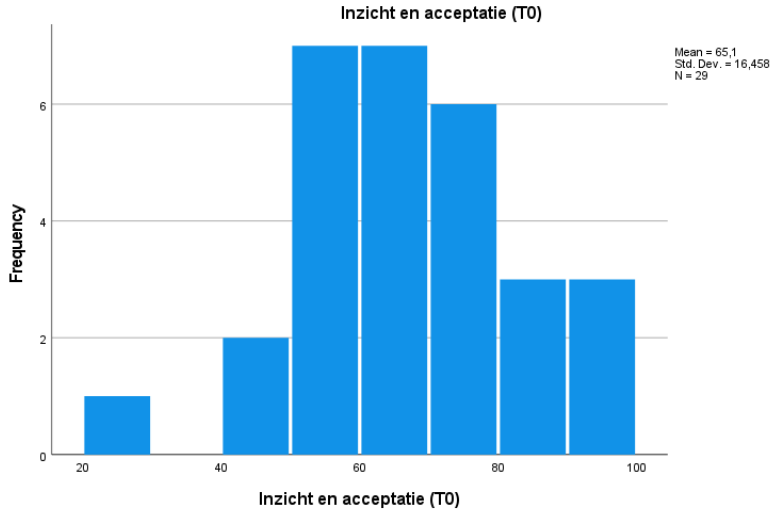


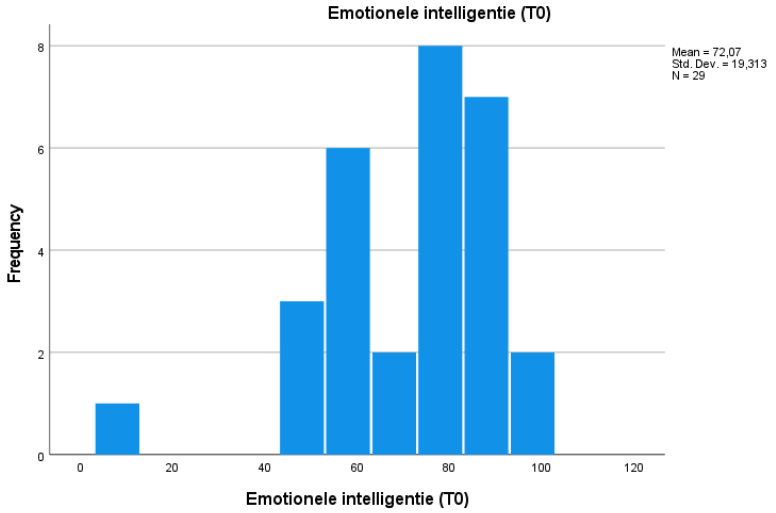
CAREGIVER SKILLS QUESTIONNAIRE (CASK) T0 – MOMS

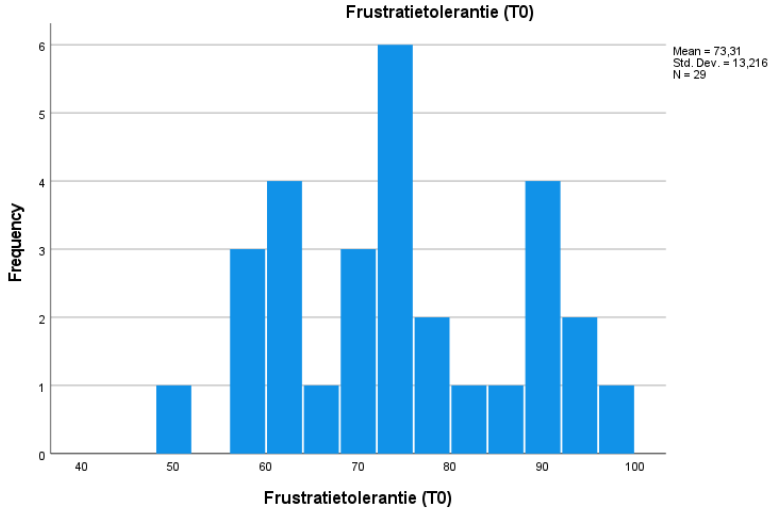




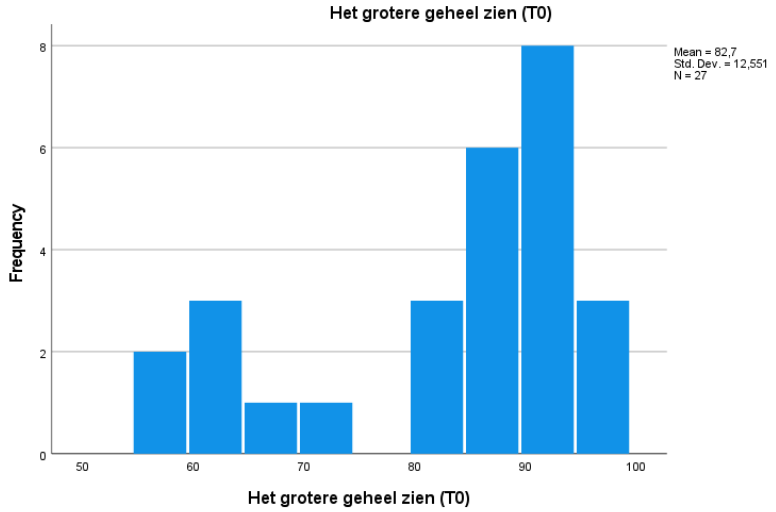


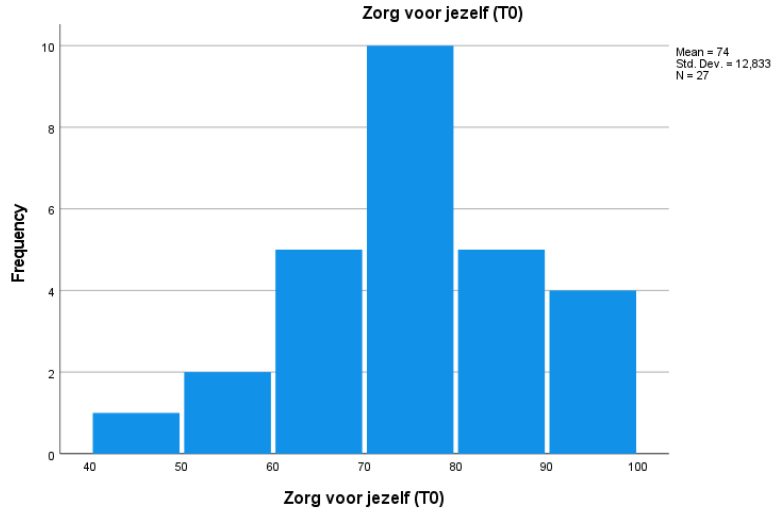


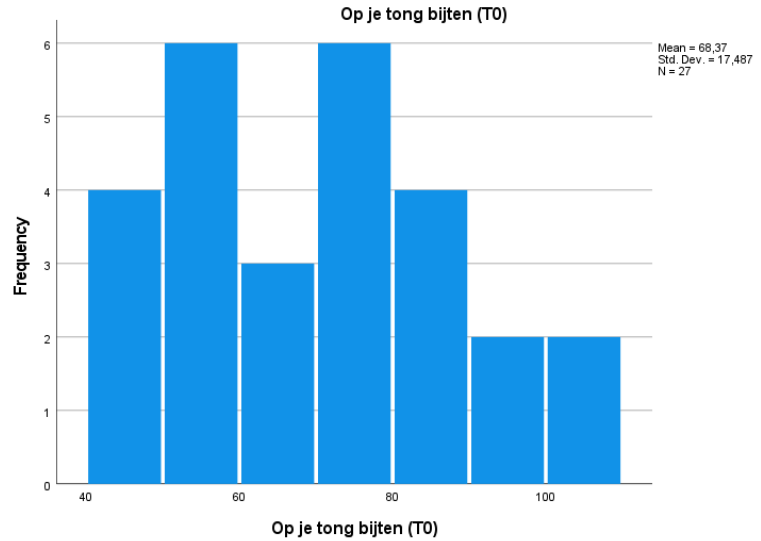


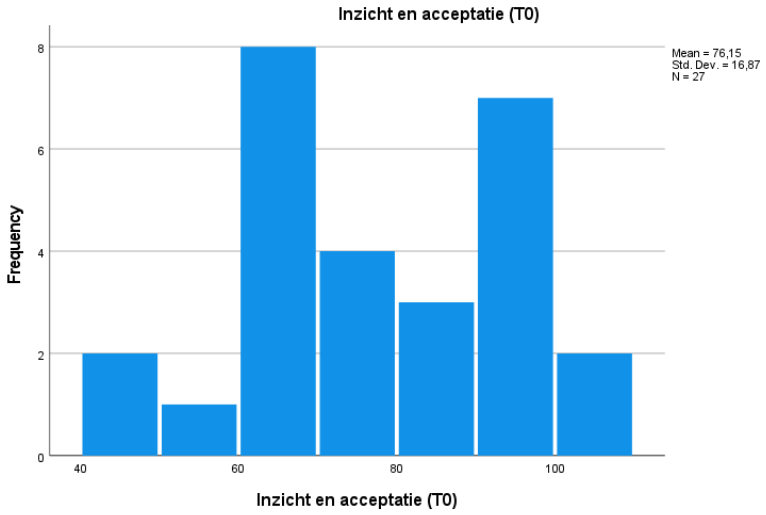


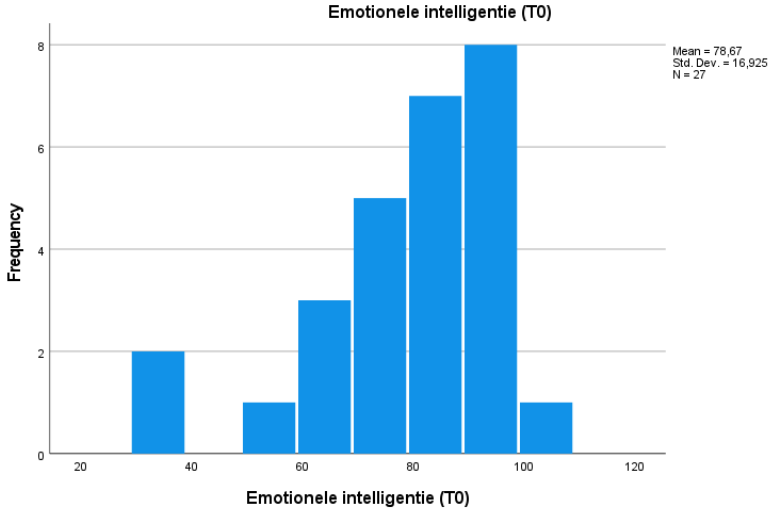
CAREGIVER SKILLS QUESTIONNAIRE (CASK) T0 – DADS

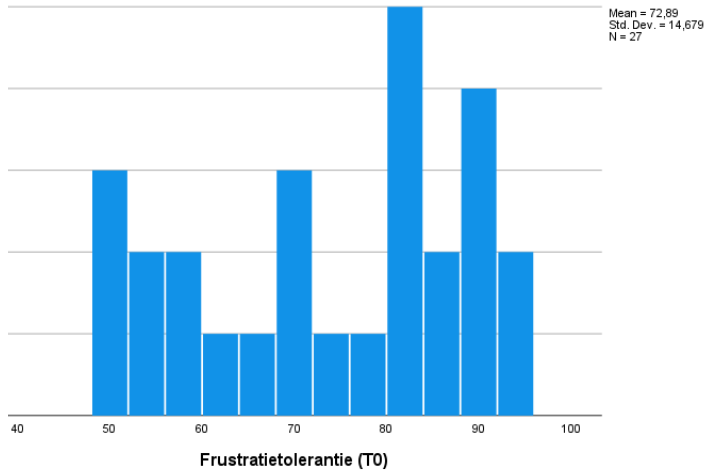








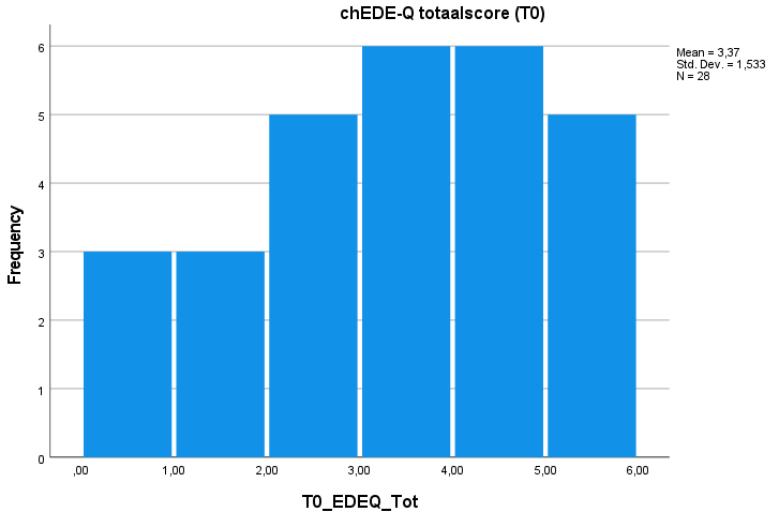




CAREGIVER SKILLS QUESTIONNAIRE (CASK) – DIFFERENCE OVER TIME(T0-T2)

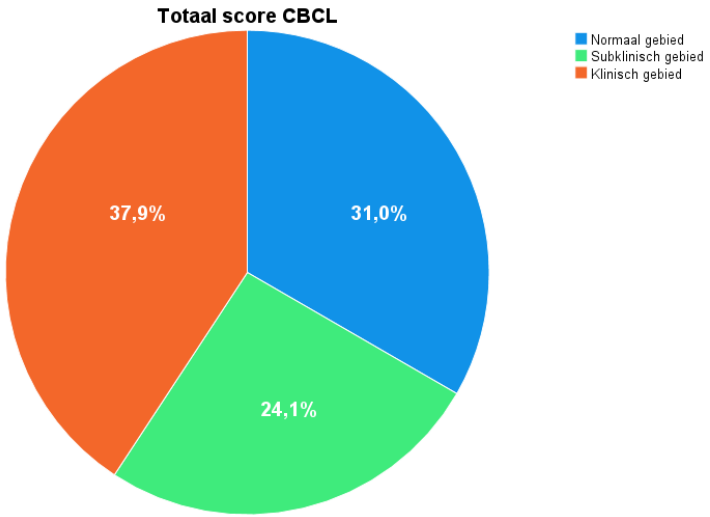
Clear improvement, although the starting point was already good!
Mothers showed stronger improvement than fathers.

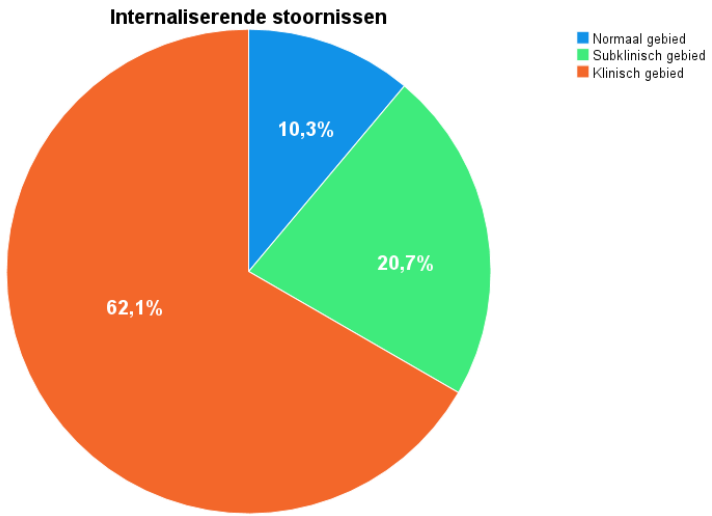
CH-EDE-Q, AND DIFFERENCE OVER TIME (T0-T2)

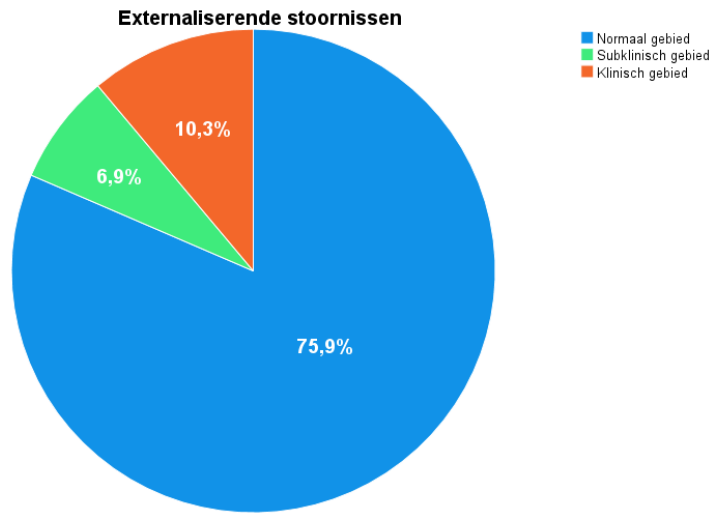


Over time, a significant improvement, $p < .001$

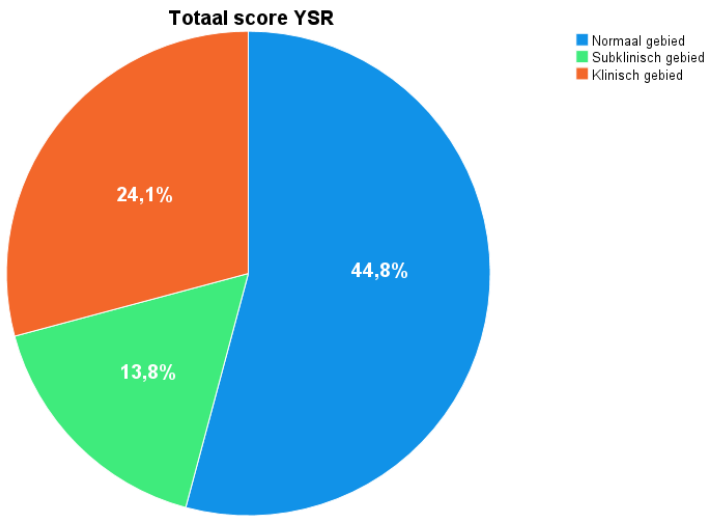
CBCL (T0 INCLUSION)

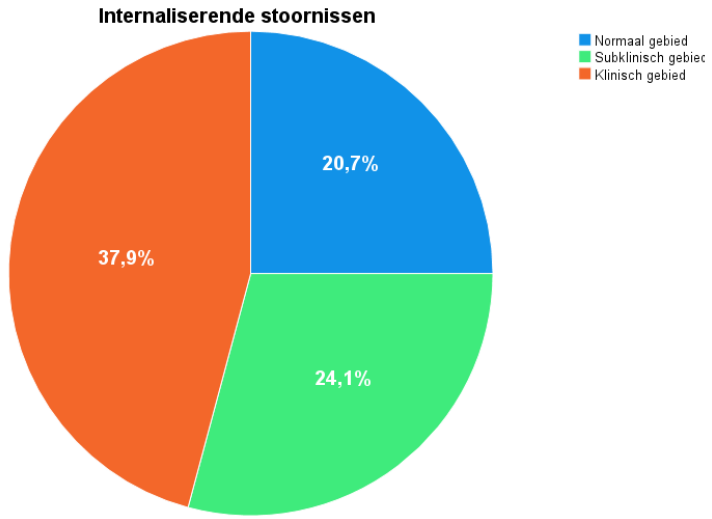


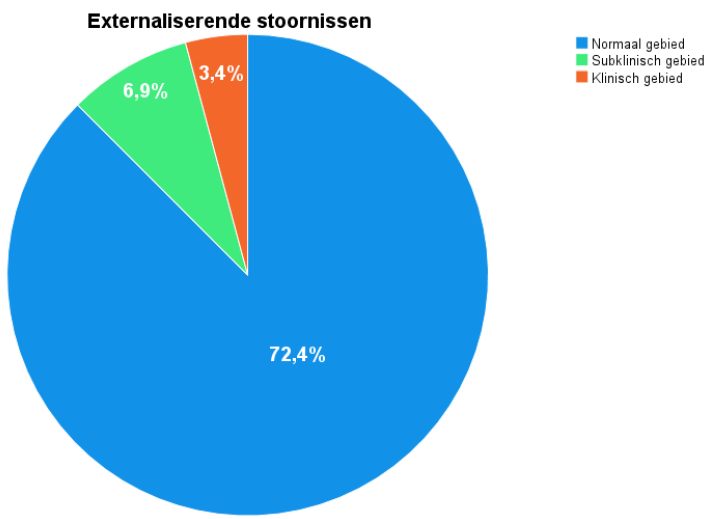




YSR (T0 INCLUSION)







THERAPY SESSIONS

Rintveld

- Mainly given by 2 psychologists, sometimes dietician involved
- No experts by experience involved
- Duration of treatment from 2 -12 months
- 17 completed, 2 dropouts eventually max 2 more sessions needed!
- Weight recovery and improved family relationships are key success factors
- Referral or co-treatment known for 2 participants (neighbourhood team and mental health institution)

EMC

- Mainly given by 2 psychotherapists, sometimes dietician involved
- Sometimes in combination with psychologist or expert by experience (3/11 participants involved in one session)
- Average treatment duration (n = 8) 29 weeks (min 18, max 43)
- Mostly weight recovery as a result (and stabilisation)
- 12 completed
- 2 internal additional diagnostics
- 3 referred externally for treatment
- 1 internally additional sessions (focus on co-morbidity)

EXAMPLES OF REQUESTS FOR HELP

- 'Help me so that I start eating normally again so that I gain weight. I find myself too thin and would really like to be able to play volleyball as normal'.
- ‘I would like to get rid of the eating disorder thoughts’.
- ‘I want everything again, but I don't want to eat’.
- Help with changing negative self-image and relationship with food.
- Investigate possible physical causes (if baby also struggles to eat)
- ‘How do I reach a healthy weight again?’
- ‘Becoming normal’
- ‘Preventing the eating disorder from getting worse’.

DISCUSSION

- What is your opinion?
- How do we proceed?
- What experience is needed?
- Next steps

OVERVIEW OF POSSIBLE CONTENT OF VIBES SESSIONS

- **Vibes session 1**
  - Feedback findings intake and family assessment
  - Clarification " incipient eating disorder".
  - Externalizing the eating disorder
  - Standing together against ED, alongside child
  - Building program
  - Addressed food, eating pattern
  - Sum of Weight: Weight = (eating + drinking) - (exercise + metabolism)
  - Anxiety/cognitions
  - Balance moving along/accounting vs. strict frameworks, difficulty for parents
  - Consider involvement of dietician
  - Pediatrician weigh-ins (follow up weight or not too much focus on it?)

Vibes session 2

- Update
- Supper atmosphere, family interactions -> How can parents help?
- VENN diagram
- Role anxiety
- System factors: is not about cause or blame, but looking at what is needed for recovery
- Follow-up pediatrician/dietician check, coordination
- Option experience expert discussed

- **Vibes session 3 (with expert by experience)**
  - Update
  - Eating list discussed: focus on what is helpful for patient versus eating disorder
  - What helps to be less bothered by ES during eating times?
  - Tips/experiences expert by experience- Writing down thoughts for more peace of mind- Re-thinking: towards more neutral/helpful thoughts- Mantras during meals- Reducing tension around meals with distractions
  - Triangle of thinking-feeling-doing
  - Park themes that do not fit within VIBES (body experience, possible perpetuating factors in other family members, school anxiety).
  - Role sibling vs parents: support vs responsibility
  - Breakdown:
    - patient conversation with experiential expert: addressing questions, PE, practice rethinking, attention to risk of isolation
    - parents with psychotherapist: how do parents keep it up, support each other, on 1 line

- **Vibes session 4 (family conversation with brothers/sisters)**
  - Update
  - Feedback dietician tune-up/experience: follow up eating list and adjust eating pattern there, make change in steps
  - Review contact experience expert, what applied
  - System: role parents vs sister
  - Sister supports, food responsibility with parents
  - Family atmosphere, how to discuss difficult moments together
  - Building up activities, "normal" life, also joint activities
  - Attention to vacations, maintaining rhythm
  - Looking ahead to the last appointment:-
    - List important themes for them that still need to be addressed.-
    - Themes where other help is needed, referral needed?

- **Vibes session 5**
  - Joint start, catching up
  - Break down
    - Individual conversation adolescent:
      - Back on previous themes: what helps when eating is difficult
      - PE eating disorder, tendency to isolate and having to solve it alone
      - School, uncertainty role ED
      - PE anxiety and avoidance
      - Relaxation exercise
      - Fixed agreements, helpful to know where you stand
    - Parent discussion:
      - eating disorder vs. puberty
      - functioning at home, school, outside the home
      - follow-up process?
    - Closure, consider referral for topics other than ES

FURTHER QUESTIONS?

- Contact:

- K-EET bouwt door info@eetstoornissennetwerk.nl
- Gwen g.dieleman@erasmusmc.nl
- Annemarie a.a.vanelburg@uu.nl

K-EET, the Dutch network approach to improve care for people with eating disorders

An example how to tackle a ‘wicked problem’ in child and adolescent mental health care

K-EET

LANDELIJKE KETENAANPAK EETSTOORNISSEN

WHO European Autumn School on

Quality of child and adolescent Mental health care

ADVICE HEALTH COUNCIL

- Lack of knowledge in society, among parents, and among (healthcare) professionals about (all) eating disorders and about the Care Standard Eating Disorders.
- Long waiting lists
- Fragmented supply of care
- Lack of a national registration system
- Lack of scientific research on early intervention and comorbidity in eating disorders

K-EET 'S MISSION

Children and adolescents with an eating disorder - or a vulnerability to it - deserve earlier recognition of their problem, better understanding and more effective treatment.

This is because early recognition and treatment leads to less suffering, fewer seriously ill children and adolescents and lower social costs.

Moreover, K-EET's mission is that no more children die as a result of an eating disorder.

Vision K-EET

Patient

Learning system

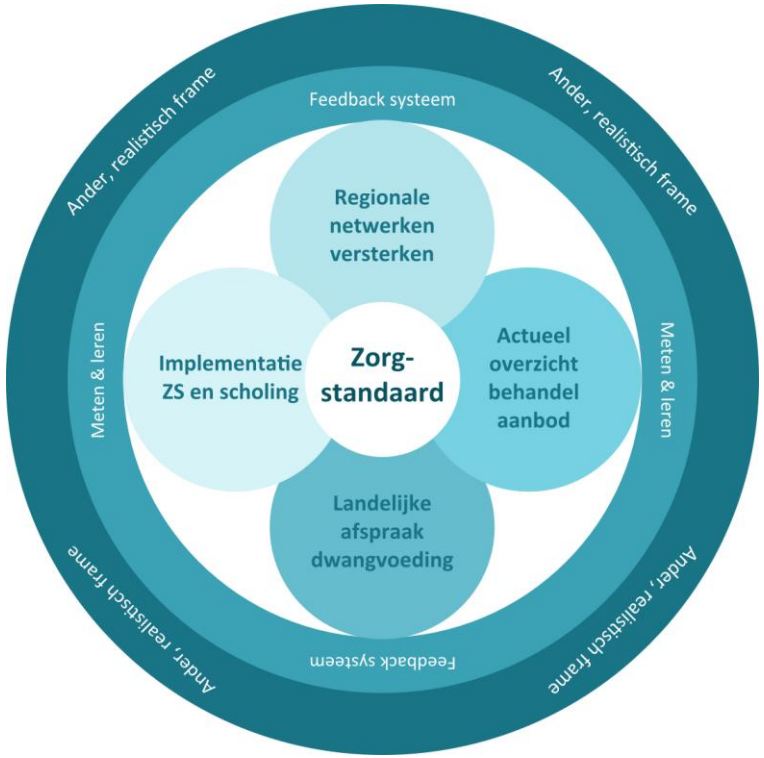
Children, adolescents and adults with (potential) eating disorders are increasingly recognised, better understood and treated earlier and better. In 10 years, there will be a significant decrease in the number of seriously ill patients at risk of death.

Best working early recognition and intervention

Best effective treatment for serious illness

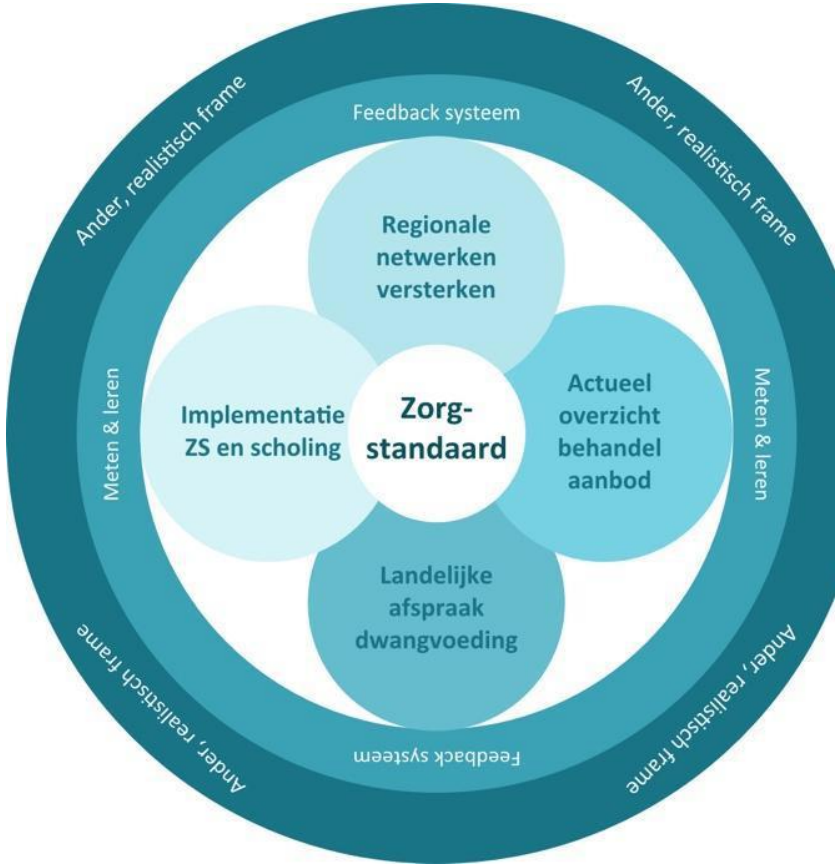
Treatment content

Organisation



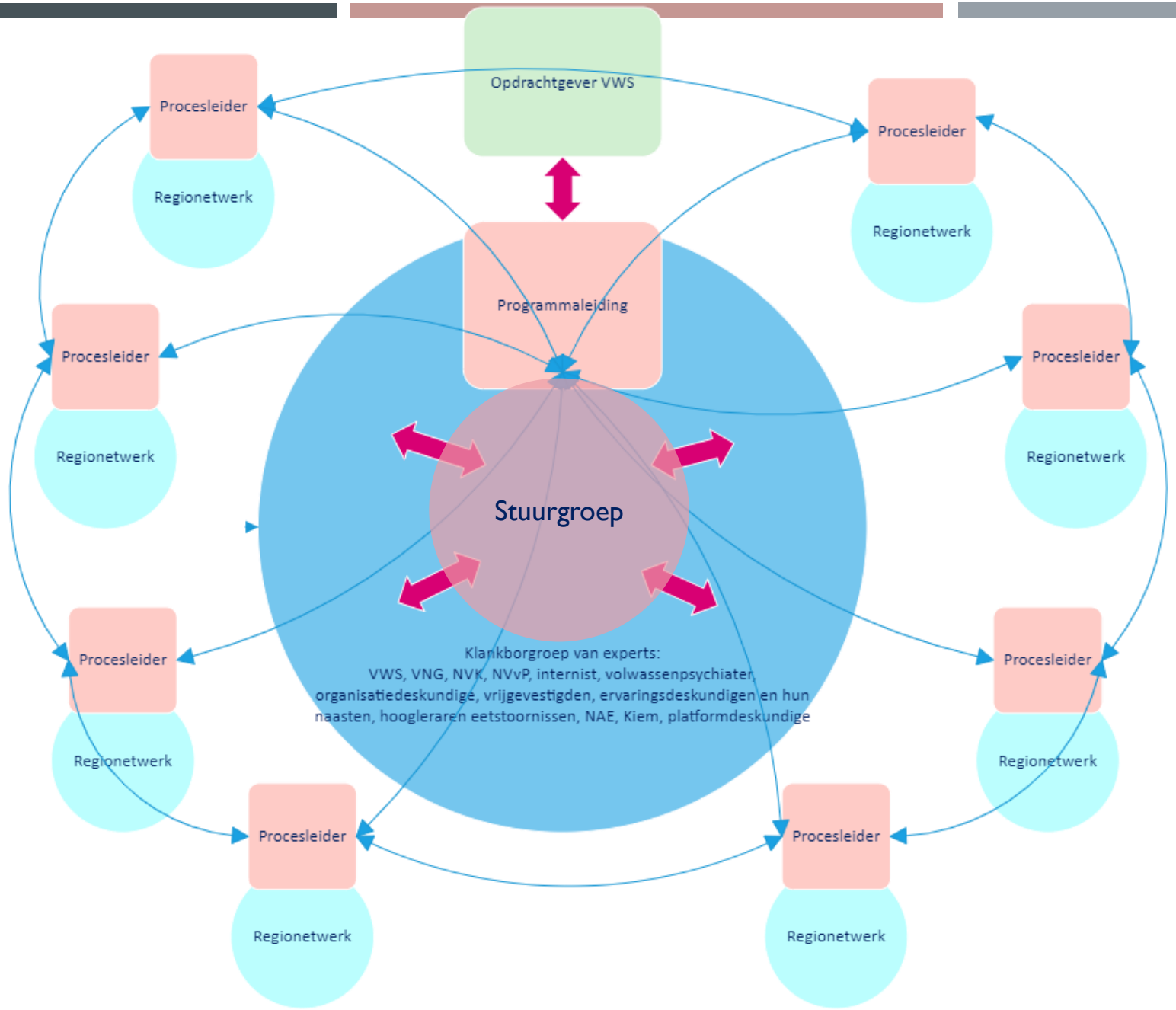
BUILDING BLOCKS

- Start of K-EET 2020, duration 3 years
- Six building blocks/solution routes
- Building block 1: (Upper) regional network with access to knowledge and expertise
- Building block 2: Good foundation on which knowledge and expertise is disseminated and can develop
- Building block 3: Up-to-date overview of treatment offerings
- Building block 4: Learning data feedback system
- Building block 5: Realistic frame around eating disorders
- Building block 6: Guidance around the prevention and use of force-feeding



BUILDING BLOCK 1: (UPPER) REGIONAL NETWORK WITH ACCESS TO KNOWLEDGE AND EXPERTISE

- Developing learning network care
- Eight supra-regional networks
- Training sessions Care standard
- Improvement of regional cooperation (GLOW, BITE, Libraz)
- Development per region
- Process leaders
- Linked to 8 BRENs


Opdrachtgever VWS
Programmaleiding
Stuurgroep
Klankborgroep van experts:
VWS, VNG, NVK, NVvP, internist, volwassenpsychiater, organisatiedeskundige, vrijgevestigden, ervaringsdeskundigen en hun naasten, hoogleraren eetstoornissen, NAE, Kiem, platformdeskundige
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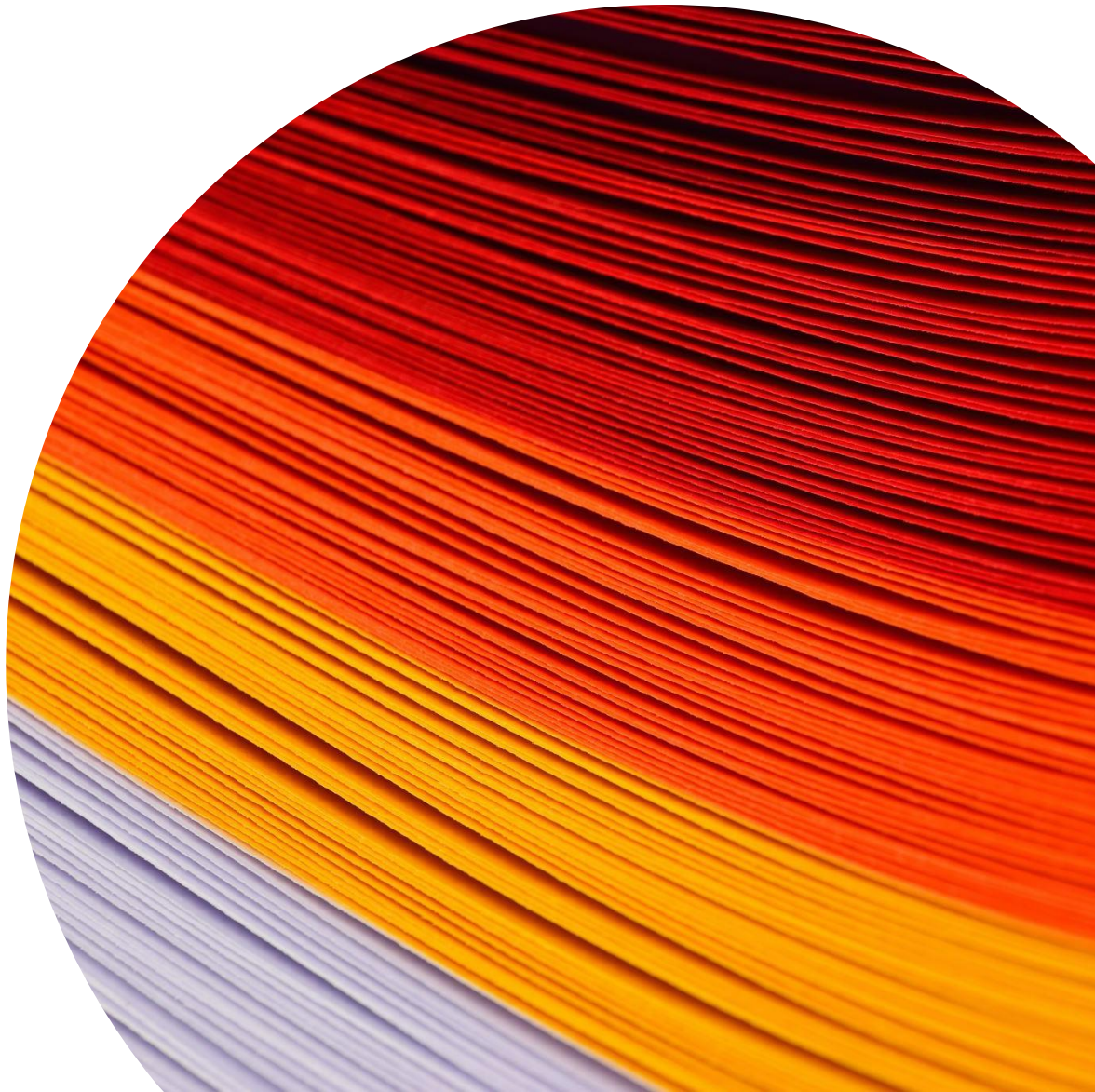
STEERING GROUP

Principles

- Earmarked time; 4 hours per week
- Free, but not non-committal thinking
- National ‘coverage
- Low-threshold availability, flexible
- Multidisciplinary ‘coverage’: all flavours, in the different phases of the condition
- Expertise
- Working in pairs



FOCUS GROUPS

- VWS, VNG, NVK, NVvP, internist, adult psychiatrist, organisation expert, volunteers, experts by experience and their relatives, professors of eating disorders, NAE, Kiem, platform expert, researchers, knowledge centre-kjp

- 4 meetings a year

PROCESS LEADS

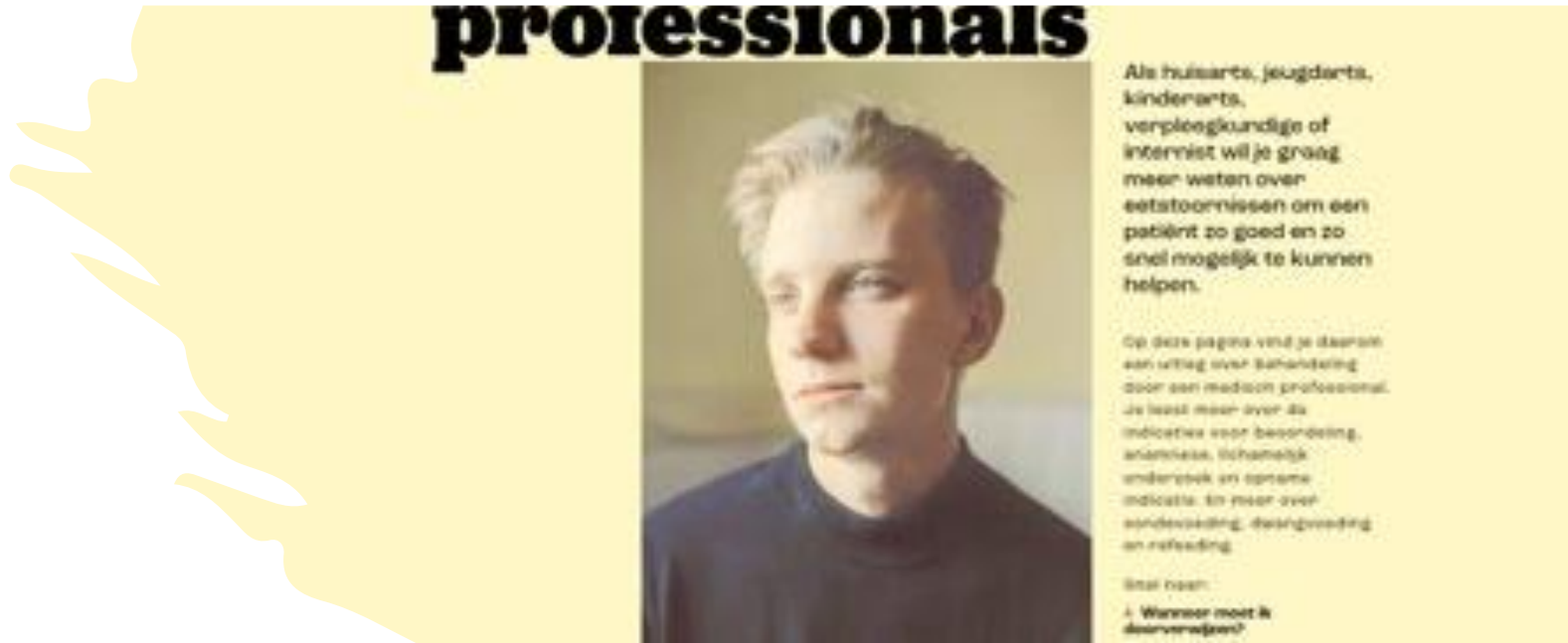
- Lots of knowledge & experience
- Different backgrounds

FINANCIAL SUPPORT

- Ministry of health = sponsor
- Client-sponsor meetings to discuss progress/hurdles
- 4 times a year
- Ministry of Health, Welfare and Sport participates in focus group, then contributes ideas on content not in role of sponsor

BUILDING BLOCK 2: GOOD FOUNDATION ON WHICH KNOWLEDGE AND EXPERTISE IS DISSEMINATED AND CAN DEVELOP

- FirstEetKit
- VIBES
- Advice line K-EET-I
- LinkedIn
- Care standard



BUILDING BLOCK 3: UP-TO-DATE OVERVIEW OF TREATMENT OFFERINGS

Eating disorder network

BUILDING BLOCK 4: LEARNING DATA FEEDBACK SYSTEM

- ‘Learning And Exchanging Knowledge Within K-EET’: LEUKK
- We aim to be able to provide regular feedback to institutions from K-EET on key figures. By sharing and through feedback, a network of institutions learns to become better together. Meanwhile, a pilot has been conducted with five institutions and a draft data feedback system (DFS) is in place.
- Two professional feedback systems elaborated for cognitive therapy (CBT-e) and for family-based treatment (FBT/MGDB). Both will be placed on the NAE's website in an accessible way for (healthcare) professionals.
- e-learning PARDI, EDE

BUILDING BLOCK 5: REALISTIC FRAME AROUND EATING DISORDERS

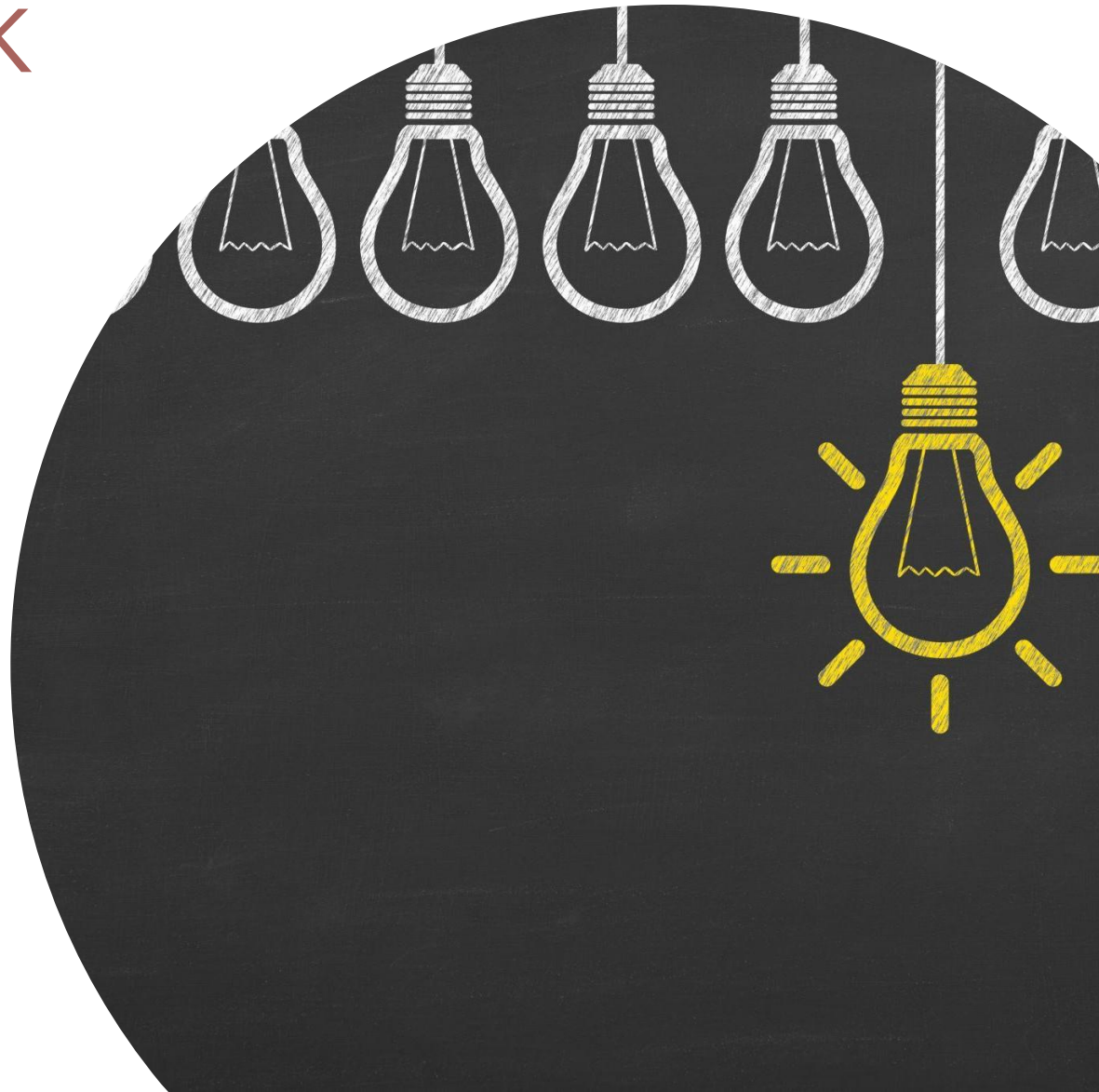
- Counter stigmatisation of eating disorders and promote normalisation at both societal and individual levels.
- Realistic frame
- Ongoing activity of K-EET is contact with journalists and documentary makers about the image they ‘portray’ in media coverage.
- Campaign WEET: It's not about food
- FirstEetCast

BUILDING BLOCK 6: GUIDANCE AROUND THE PREVENTION AND USE OF FORCE-FEEDING

- National learning network
- Guide
- Siilo app
- Peer review
- Second opnions

SUCCESS OF K-EET AS A NETWORK

- Drives and connects, provides unity and development in fragmented field.
- Cooperation between healthcare professionals from different disciplines, professional associations, patient associations, healthcare providers, policymakers and funders.
- Cooperation nationally, regionally and supra-regionally facilitated by K-EET organisational structure.
- Professionals and experts by experience at the wheel, content is leading, hands-on mentality.
- Earmarked time, free but not non-committal thinking.



GUIDING PRINCIPLES

- Hope, positivity, energy
- No attention bumps
- Open and constructive
- Direct communication
- Just start
- What cap are you wearing?

LEADING PRINCIPLES

Solicited and unsolicited advice, seeking counter-thinking on complex questions is normal

Cooperation agreements on the best suitable help, within regions and nationally where necessary

Solid financial basis for network connections & activities

Working from a uniform content framework, based on current knowledge, care standards and practice

There is room for innovation

Quality criteria against which a network can be assessed

FURTHER QUESTIONS?

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