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Case Example:

Adolescent with Anorexia Nervosa (AN) treated using FBT

Meryl*, 16-year-old female, early onset AN in the context of parental conflict and concern about the Year 10 exams. Comorbid low mood with safety risk; Meryl presented following admission to hospital for medical stabilisation. There was no purging, but some driven exercise.

Core element of treatment	Telehealth variation
Engagement	• Parents were unfamiliar with FBT at the start of treatment. Usually I would speak with one or both parents in making the appointment, and would provide a brief description of FBT and the need for everyone to attend together. I do not typically send a letter prior to the first session as per the manual, but I do ring the parents the week before the session or send an email reiterating the gravity of the crisis and the importance of everyone attending. • These parents did not feel able to commit to family therapy during lockdown with everyone in the family home and felt there were circumstances they needed to discuss before proceeding; felt COVID-19 had stressed things for the family, with everyone struggling with home schooling and work. We set up an initial parent session via telehealth.

	• During that session we were able to plan who would and would not attend the sessions. The family was blended, with a substantially older sibling from a previous marriage whose attendance was deemed to be unhelpful. Two younger siblings from the current couple's marriage were to attend sessions. • During the parent session I was able to provide more than usual information about FBT and what would need to look different at home. We were able to focus specifically on the treatment set-up, including that parents would need to use a device that everyone could see/hear and be seen/heard on, as well as be able to talk to each other. • I set treatment expectations that everyone in the family was to attend, and while it was lovely to have pets around, if they became a distraction to treatment, we might need to problem-solve this. I specifically talked with the parents about where they would call from; getting siblings ready before the session, rather than bellowing for everyone to "drop what they were doing" and attend moments before the start of the session. We talked about ensuring no-one got up to check another device, or get anything from the kitchen during the session, as the house was open plan, and they planned to call from the couch, just in front of the kitchen. We were able to discuss the weigh-in and how that would happen (details below). • I charged the parents with ensuring everyone attended the session with the expectation of focusing on Meryl's concern for the time we spent together. ○ Note: I feel this extra time spent with the parents set treatment up a lot better than those I haven't done this with, and have had difficulty, with some families, after starting sessions via telehealth ensuring appropriate attendance and engagement.
Assessment	• The family then attended an initial session including Meryl, who was typically unhappy about attending and concerned about having her family attend. This is no different from in person. • Assessment measures were sent via email as is typical for our practice.
Treatment non-negotiables	• Meryl was required to see her paediatrician/GP for weekly review until medically stable. • Any safety concerns were discussed openly with parents and problem solved as they arose. There was little difference in managing these than there might have been in person. • During treatment, there were some behavioural escalations followed by increased safety risk. We planned to manage these as I typically would, with parents managing access to risk as possible or accessing services appropriately when needed. On a single occasion, things escalated to the point that parents took Meryl to

	hospital for complete food refusal; on another occasion escalated distress led to Meryl putting her hand through a window, leading to another visit to emergency.
Weighing	• Parents were given the option of taking Meryl to the GP for a weigh-in weekly, or to purchase scales and manage this themselves. They had little concern about Meryl overweighing herself if there were scales in the home as she had not done so previously but were concerned about the potential for them weighing her to lead to increased conflict and distress, so elected to have the GP weigh her weekly. ○ Note: I have had other families elect to weigh the young person themselves, either prior or at the start of the session. Typically this has gone well, but I have found it hard to have parents step back from the need to monitor the weight when young people recover, so while simple and practical, don't always think this is the best option and would prefer to have a medical practitioner manage the weight with adolescents where possible. • Agreed I would contact the GP weekly for the weight and would maintain the weight chart, which would be shown via shared screen in every session.
Engagement with young person	• I would always spend the first 5-10 minutes with the young person to talk about the weight, and anything that had been challenging for the week, and to get to know them. This was no different with Meryl. ○ Note: Setting up where this part of the session could take place without the rest of the family present was challenging for some families, and could take a little longer than usual to plan.
Session 1: **The intense scene**	• There was very little difference undertaking session 1 via telehealth than in person. The only notable change was to be more prescriptive in saying that everyone would have a chance to speak, and to manage the tendency for families to talk over each other. It is quite challenging to hear a large family when all are speaking at once; often added to by poor internet quality. I was more explicit in saying that if everyone was talking over each other, we'd need to stop until I was able to hear; I would ensure all would have a chance to say what they needed to. • All elements of the first session including engagement with the whole family, externalisation of the illness, challenging guilt, the intense scene, charging parents with the responsibility of refeeding, and setting up the family meal were managed as they would be in person. ○ Note: In person, I typically run this as a one-hour session, but have found myself running it as an extended session as a lot of the set-up of treatment (described above) would typically occur in this session when working via telehealth.

Session 2: **The family meal**	• We planned what the meal might look like at the end of Session 1; as is typical I charged mum and dad with the responsibility of planning the food and indicated the aim of the meal was to help Meryl eat one more mouthful than AN wanted her to. • We discussed how to position the camera: Instead of on the couch, the family elected to eat at the dining table; they set up an iPhone or iPad on a set of books, so I would be able to see them, and the food. • The toughest part about Meryl (and others') family meal is that when distress is heightened it is hard to be heard as a clinician. I found this meant I turned more to siblings to calm their sister than I usually might in an in-person session, and to allow more space for everyone to breathe and calm before I coached the parents. Initially this was uncomfortable for me, as part of the agent of change in the meal is probably the heightened intensity of the situation, but I have found providing more space before I coach to mean parents are a bit more grounded and able to take the coaching on board. • The family pet (a dog) ended up being problematic, but this was a good time for the family to notice. She was always present at meals; it emerged during the meal that Meryl was feeding her substantial food scraps to reduce her own intake. The parents were able to make the decision together to put the dog outside for the duration of the meal, and that they would maintain this for future meals, until Meryl was somewhat more able to manage the urge to feed her. • Meryl did leave the session during the family meal. Her parents were able to go to her room to fetch her and bring her back to continue. ○ Note: There have been as many changes made in this session as I have seen families during COVID-19, with each family's situation being a little different. However, when working with families at home, I let parents know that the benefit of being at home, is the kitchen is right there and we can always get more food if need be. While Meryl (and others) pushed back as is typical in a family meal, my observation is the knowledge parents could get more food was somewhat containing. There was a stronger message in this meal and others that parents would be willing to continue until the food was finished, as they did not have the forced ending of having to leave a therapist's office, or the pressure of needing to get somewhere else after the session.
Setting up meal supervision	• Meryl's father had not been involved in food or shopping previously, but now working from home, he was able to share these tasks with mum who was also working from home. This provided more support for mum.

	○ Note: I have found meal supervision to be successful and easier during lockdown. Both parents were typically at home, so where working parents had previously been tough to engage around meal support, being at home has helped parents become more involved and collaborate more easily. • For Meryl, and other families, things became more challenging once schools returned to in-person attendance. Even though they were towards the end of Phase 1 when this occurred, Meryl struggled to eat independently when school resumed. Parents wanted to give her two weeks to try on her own. When the weight fell, and with dad back at work, parents struggled to commit to providing supervision of school meals. This was a sticking point for Meryl's treatment and opened up some of the parental conflict, which I managed by having two parent sessions to explore obstacles and solutions. ○ Note: Typically, parents would supervise in the earlier stages of treatment, but had to do so somewhat later in Phase 1 and found this challenging.
Treatment progress	• Meryl is struggling to transition to Phase 2. She is weight-restored, and safety risk settled midway through Phase 1. The family are working to help her get back on track with her peers. That was initially harder during lockdown when it was challenging to see friends. She was able to see them via virtual catch-ups, but parents were not able to plan to have friends come over, or sleep over, to support social eating challenges. I would say treatment was somewhat set back also by not being able to do challenges such as meeting friends after school or at a food court as an example, to practice more independent eating. The family got creative about having take-outs more often, and using ordering off take-out menus as a way to help Meryl practice ordering a little more independently. Meryl is just starting to have an after-school or weekend catch-up with friends, and is finding this a challenge. On balance, treatment has progressed well but has been slowed by lockdown and the subsequent need to challenge elements of recovery a little later than would be typical in treatment.
Main treatment challenges	• Maintaining sibling engagement is challenging in any FBT, and I think is harder on screen. Because a lot of time is spent managing the many voices in a family on one screen, it often means cutting short conversations one might typically have with siblings; so managing sibling boredom throughout sessions took more work. • Doing a lot of the eating challenges and social eating with a teen felt harder during lockdown, and not just with this family. • Managing conflict on the screen can be harder in that once many voices are raised, it is much harder to assert yourself in the session. I never struggle with this in person, and have struggled more via telehealth. • Ensuring the ongoing involvement of both parents after a period of financial strain, when one or both parents returned to work has been tough, and I don't have good answers on this. Only that hopefully by the time they

	return to work, parents have created good ways to communicate and operate as a team. I have found that this change did not always stick, but knowing this has had me work harder at talking about it with parents, when return to work comes into the focus for families.

***Please note:** All names and identifying information have been changed; to protect the identity of clients, the cases presented here represent an amalgamation of a number of cases such that no individual could be identified by any element of treatment presented.