

What to say and how to say it: Connecting with the eating disordered adolescent at the initial consultation

An approach used in the Eating Disorders Program at BC's Children's Hospital can help the family physician who is meeting with an eating disordered patient for the first time.

ABSTRACT: The family physician who is presented with an eating disordered patient and the patient's family faces a number of challenges during the initial consultation. In the Eating Disorders Program at BC's Children's Hospital we have found that a number of key principles and strategies can help forge a therapeutic alliance with the adolescent patient and patient's family. These principles and strategies include understanding the patient and family's anxieties, fears, and hopes; considering issues of readiness and motivation; communicating a model for understanding eating disorders; being emotionally oriented; using language that helps the physician connect with the patient; and sharing information.

The initial consultation with an eating disordered adolescent and the adolescent's family may well be one of the most challenging interviews the family physician has to conduct.¹ Varying periods of time may have elapsed between the onset of eating disorder symptomatology and the child's parents becoming aware of the problem and its severity. Parents generally find out about their child's symptoms through a variety of means. Often the youth themselves will tell their parents about how they are struggling, but parents may also receive calls from a concerned family friend or peer of the child, or from a school nurse or counselor. Parents may discover the disorder directly through seeing vomit around the house or noticing their child's emaciation. Sometimes, by this point, the illness has reached a marked degree of progression and the child may be cachectic or may be bingeing and purging with considerable frequency. The physician might receive a panicked call from a parent who will want to bring the youth in for examination, sometimes in a crisis.

The Eating Disorders Program at BC's Children's Hospital (BCCH) has developed a process that we find very helpful in meeting with the patient and parents for the first time. While for us this process involves two meetings, one before and one after a multidisciplinary assessment, many of the principles and the strategies used are relevant to the family physician. We would highly recommend that the physician consult the work of Strober,^{1,2} as we have drawn heavily on his thinking, both in our approach to the consultation process and in the ideas expressed in this article, and have paraphrased his sample discourses with patients or quoted them directly.¹ Also, in the discussion of the

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consultation process that follows, we have often referred to the patient as female, for convenience's sake.

Key principles and strategies

While we do not want to be alarmist, we do feel a great sense of responsibility for the conduct of the initial consultation with an eating disordered adolescent as the stakes can be high.¹ If the first meeting is mismanaged, it is possible that the youth may refuse to return and may go on to become increasingly compromised both physically and psychologically. Further, the patient may lose critical time needed to accomplish key developmental tasks.¹ For example, the eating disorder may impede her developing identity and increasing interdependence with family members, and it may also interfere with the formation of normal peer relationships. The patient may, if the experience is truly negative, be even more reluctant to seek treatment in the future, and may come away feeling more hopeless about change. The patient may even assume that the physician feels the same way about her that she feels about herself,³ which is to say very negatively.

Before meeting with the patient and parents, it always helps to consider the perspectives of each party involved in this initial meeting. Both the patient and her parents will have a number of anxieties, fears, and hopes in coming to the consultation, and a range of dynamics may be observed that can yield valuable insights into the factors involved in the onset or maintenance of the eating disorder.

Understand the patient's perspective

The patient will likely have experienced a number of anxieties about the consultation as the date drew nearer. (Sometimes parents who fear their

child's reaction to the consultation will withhold information about the referral until shortly before the appointment). The youth may say the eating disorder is her fault, and she may feel she is not sick enough to justify taking up the physician's time. Alternatively, the patient may feel that she is not sick at all and doesn't have a problem. She may say that she does not deserve treatment,³ and she may fear that those in authority positions will attempt to take over control of her symptoms. The patient may hope for a quick and easy answer to the feelings she is experiencing, or at least a black-and-white answer, and may hope that treatment will not involve her gaining weight. She will wonder what will happen in treatment and what the health care professionals will be like. The patient may also hope that she does or does not have an eating disorder, that the physician will understand her, and that the physician will take her part in conflicts with her family. She will hope for support and recognition of her suffering. The patient may be angry with her parents but hope that they will understand, fear that her confidentiality or privacy will be breached, and wonder whether the physician will still like her after all she or he will have heard. Her angry feelings may well be displaced onto the physician.

Understand the family's perspective

The patient's parents may fear that their daughter will not accept the necessity of treatment or that the physician will see the illness as due to their failings as parents or even directly as their fault. The parents may fear being exposed and not seen as unique, and they may be fearful for their other children. The physician may well wish to speak with older siblings as well, to help them better understand what their

sister is experiencing. Parents may also be afraid that the physician will not be able to help them. They may hope for a fast "cure" and a complete recovery, and to hear that their child will outgrow the illness. They will be hoping that the physician will be able to "fix" their child and they may want the physician to be the authority figure. Parents may want something concrete to follow, such as a meal plan and prescriptions regarding what they should do under various circumstances during conflict at home over food and eating. They will have needs and expectations regarding diagnosis and prognosis, and will want to feel a sense of confidence and trust in the physician.

Consider readiness and motivation

During our meetings at BCCH, we use a Stages of Change model, as discussed elsewhere in this issue (see "A new treatment approach to eating disorders in youth").^{4,5} We may say to the patient, "People often describe two parts of themselves to us. One part is perhaps hoping for a life not spent obsessing about food, calories, and exercise, and the other part is very fearful of any change and wants only to remain in the safety provided by the eating disorder. Do you experience anything like this?" A patient will typically acknowledge that she does experience these different parts to herself⁶ and can then be asked what percentages she would ascribe to each part. This enables the clinician to more directly understand the patient's degree of ambivalence regarding treatment and what she may see herself having to "give up" if she lets go of her symptoms. Using such a model also helps parents understand their child's thinking with respect to the prospect of change. Parents may well assume that their child is at a higher stage of readiness for change than she

actually is.⁷ By better understanding this situation, parents may feel less urgency and panic.

Use of the term “readiness” with the patient and family is helpful as it conveys the idea that the patient is capable of change and that it is more a question of having to “get ready” to take the next steps. This also helps steer the discussion away from “all or none” conceptualizations of the process of change.⁸ Parents can also be helped to understand that change is a fluid process and that it is very likely their child will move back and forth between several of the stages of change.⁷ The “Why Weight?” psychoeducational group manuals give an excellent overview of this process for both parents and youth.⁷

Communicate a model for understanding eating disorders

It is essential for the physician to have a model that guides her or his thinking on these disorders.¹ We find the model outlined by Strober provides clear and helpful guidelines for the clinician.^{1,2} According to Strober, the eating disorder can best be regarded as a response to a developmental crisis.¹ We will often explain to the patient and family that the eating disorder is a solution, even though it has become an issue in itself. We indicate that we can understand why the patient would cling to it as it offers things to her.¹ In other words, it can be seen as a friend as well as a foe.⁶ We also indicate that the eating disorder is a kind of language that the patient is using to express to the world that she is not feeling very good about herself. It may be explained that one of the goals of treatment is to help the patient understand what it is she is wanting and needing to convey or express, and help her to find alternative ways of expressing her needs and wants.

Be emotionally oriented

Adolescents clearly become less present when the clinician engages in a lengthy and dry discourse about diagnosis and treatment recommendations. In our program, we attempt to bring important information alive for the patient and family by being emotionally oriented. The sharing of this infor-

der into the patient’s sense of who she is as a person.¹⁰ For example, terms such as “your” or “her” eating disorder should be avoided. It is critical to convey to the patient that the patient is first and foremost a person rather than an “anorexic.” By asking the patient about the eating disorder’s effects on her life and the family’s life, the eat-

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mation needs to be tied as closely as possible to our understanding of the particular patient’s experience of the eating disorder. It will fall far short if it is articulated based on general principles alone. We have found it helpful to use strong language in discussing the model and recommendations.¹ For example, we may say, “We can understand what your life under anorexia must be like, consumed as you are with whether to eat or not eat, exercise or not, or throw up or not throw up. Do you ever feel you have a break from the relentlessness of negative feelings about yourself? And does the eating disorder convince you that others also feel negatively about you?”

Use effective language

We have found it very helpful to use the “narrative” model with respect to language.^{3,9} This essentially involves avoiding collapsing the eating disorder

into the patient’s sense of who she is as a person.¹⁰ For example, terms such as “your” or “her” eating disorder should be avoided. It is critical to convey to the patient that the patient is first and foremost a person rather than an “anorexic.” By asking the patient about the eating disorder’s effects on her life and the family’s life, the eat-

Share information

The physician must exhibit openness and transparency when dealing with both the patient and family. Being elusive or avoiding difficult topics is counterproductive to developing an alliance with the adolescent. Questions must be welcomed and the patient and family must be encouraged to ask about anything that concerns them throughout the assessment process. Transparency is demonstrated best through a willingness to share information and to be asked questions.

The Eating Disorders Program process

In our program at BCCH, the clinical director and a nurse meet initially with both the patient and her parents for a half-hour, whereupon the actual assessment process begins. Following the various assessments (diagnostic interview, medical evaluation, and psychosocial assessment), we meet again with the patient and family for a lengthier discussion of some of the findings and to present recommendations. The goal of both these meetings is to begin the process of forging a connection with the adolescent and her family. We have found that a powerful strategy is for the health care professional to frame the discussion in emotional terms that will encourage the adolescent's interest in a treatment relationship,¹ and as a result give rise to a sense of hopefulness.

We recognize that as part of a program based at a tertiary centre we have

Table. Speaking with patients and parents during the initial consultation for an eating disorder.

- Have a model for understanding eating disorders that you feel comfortable articulating.
- View the eating disorder as a "solution" for the patient.
- Expect the patient to be ambivalent about treatment.
- View the eating disorder as separate from the patient as a person.
- Meet with the patient alone initially, then with the patient and family together.
- Validate the patient's suffering due to the eating disorder, and the parents' anxieties, hopes, and fears.
- Outline and practise a "nonblaming" philosophy.
- Avoid using jargon.
- Exhibit transparency with respect to your intentions.
- Utilize a Stages of Change model (see "A new treatment approach to eating disorders in youth" in this issue).

the benefit of a multidisciplinary team, and that the primary care physician may not have access to other professionals at first. Nevertheless, we feel the general structure of the process used by our program can be used by the family physician for the initial consultation and can be adapted to the practice of the solo general practitioner. The **Table** summarizes recommendations for conducting this initial consultation.

Goals of the initial meeting

During the initial half-hour meeting we try to accomplish the following:

- Greet and welcome the patient and parents.
- Inquire if the patient and parents received the assessment materials and information.
- Acknowledge and validate the patient's ambivalence.
- Acknowledge everyone's feelings about being there.
- Ask each person, "What would you like to get out of today?"
- Help each person to feel safe and comfortable.
- Discuss self-blame openly.
- Review the process of the day.
- Review the nature of and limitations to confidentiality.
- Review subsequent meetings and schedule.
- Ask each person, "Is there anything you'd like to know?"
- Observe any family dynamics.
- Assess how well attuned the parents are to their child's suffering.

No matter what the setting for the meeting, the clinician needs to be an active participant. There is no room for a passive or psychologically distant stance. In our program, we go out to the waiting room and always identify ourselves and greet the adolescent first before introducing ourselves to family members. We would recommend that the physician initially meet

with the youth alone and then with the parents together with the adolescent.

We do not meet with parents without their child being present. Occasionally a parent will indicate that she or he wishes to meet with one of us alone. Generally this is because the parents want to relay information to us that they think would be upsetting for their child to hear. However, it has been our experience that a more satisfactory outcome for these meetings is achieved when the physician models a sense of openness and avoids participating in a dynamic where secrets can be maintained or even flourish. A similar dynamic may be observed when parents submit material, such as their child's journal entries, and indicate that their child is unaware that they have this material. Many such issues can arise at this critical time in the consultation.

The diagnostic interview

Once introductions are made, the physician needs to take charge of the interview by setting a welcoming tone and acknowledging the struggles that have likely led to the patient and family arriving at the office. After some social banter we tend to set the stage by turning to the adolescent and saying that in our experience people arrive for the meeting with a variety of feelings: sometimes with anger and the belief that they were dragged to the meeting by others (usually their parents) and at other times looking forward somewhat to learning more about what sort of help might be available. We then express curiosity about how the patient felt coming for the interview. Having started with examples of how others have felt allows us to avoid telling the patient how she is feeling or implying that we are the experts on her experience of the eating disorder. We can thus encourage the expression of her story about her

own unique experience. We then ask her parents how they felt about the appointment.

The physician meeting with an eating disordered adolescent and her family needs to take care not to replicate possibly unhealthy family dynamics. Although it may not be apparent, the adolescent will be watching very carefully and assessing the degree to which she will be able to trust the care providers. The importance of listening and attending, as well as empathic responding, cannot be too strongly emphasized here. The physician needs to validate feelings. It is essential in this regard that the physician have a well-thought-out model for understanding eating disorders and their treatment.¹ This will be critical in responding to any questions that arise. Both the adolescent and her parents should be encouraged to ask any questions throughout the course of the assessment. The patient should be encouraged to be an informed consumer of health care. The physician may need to engage in appropriate limit-setting during this meeting, as the fears and anxieties discussed above will need to be appropriately managed and contained.

We routinely ask parents how they think their child has been feeling. There are several reasons for this: first, it gives us an idea of the degree of empathic attunement the mother and father have to their child, and it takes the emphasis off eating disorder symptoms per se and provides an opportunity to validate what it is the patient has been feeling. It also allows us a glimpse of how psychologically aware and mindful the family is regarding the world of feelings.

We also talk about our philosophy in the Eating Disorders Program being one of “nonblaming,” as it is common for the patient, and her parents, to have blamed themselves for the difficulties

at home. The patient will most often have a very low sense of self-esteem and will likely attribute family stresses and conflicts to deficiencies in herself as a person. Parents may do similarly, often having engaged in a process of scrutinizing past family events for what they feel they should or should not have done that may have caused the eating disorder. The patient and her parents can be told that the causes of eating disorders are complex and that it doesn’t make sense to point the finger at any one single event or person. What is most important is to decide how the parents can best support their child in the process of recovery. It may be helpful to explain the difference between searching for cause or blame and taking responsibility for one’s current and future actions. We may say, “While this may sound odd, if anyone is to blame, it is the eating disorder. After all, the eating disorder itself has encouraged all of you to question yourselves in a way that can paralyze your ability to move forward from here.” At the same time that we talk about the eating disorder not being anyone’s fault, we also speak about how important families are in helping the young person recover. We may say to the parents, “Without your encouragement and your ability to help your daughter understand possibilities other than the continuation of the eating disorder, it will be very difficult for her to give up symptoms that actually serve as a solution for her.”

In consultations for the Eating Disorders Program, the adolescent is told that we will not be forcing her to do anything that day (unless there are safety issues) but that we will be making recommendations that she and her parents need to discuss. We emphasize the fact that she will have some choices that need to be considered with family members after they leave

the office. We ask the patient what her understanding is of confidentiality. We find that most adolescents have a good grasp of this, which we are then able to validate as well as giving an explanation of how this works specifically within the context of our health care team. The limitations to confidentiality are discussed with her parents present. At times we will articulate that there is a distinction between “secrets” and “confidentiality.” Confidentiality is not generally stipulated by us if the patient is less than 12 years of age. While the Infants Act of British Columbia does not specify a lower age for the capacity to provide consent, we use 12 years as a generally lower age limit for this purpose.

Following the diagnostic interview and the medical and psychosocial assessments patients undergo in the Eating Disorders Program, the team has a triage meeting for half an hour to discuss the diagnosis and treatment recommendations. We look to the assessment team for any information that will help us connect with the patient and her family during the subsequent meeting. For the solo general practitioner, this may mean taking the time to plan your recommendations before meeting with the family and patient again. Planning appropriate recommendations may involve reviewing notes and consulting with colleagues who work in the area of eating disorders.

Goals of the final meeting

During the final meeting, we try to accomplish the following:

- Thank the patient and parents for attending the assessment and meetings.
- Recognize strengths.
- Provide some feedback about diagnosis and any immediately relevant medical information.
- Briefly present a way of understanding anorexia nervosa or bulimia

nervosa and their treatment that validates the patient's hopes and fears, encourages her interest in a treatment relationship, and also engages her family.

- Present recommendations.
- Discuss treatment options fully so the patient and family can return home to consider what course they would like to pursue.

Our intention with this meeting is that the patient will have "been witness to an experience that gives her reason to hope for a less painful alternative"¹ to the eating disorder.

At the conclusion of the final meeting, the patient and family are asked to consider the recommendations and let us know at a later time how they would like to proceed. If we don't hear from them within a week or two we will call them. In completing the meeting, we discuss where any reports should be sent, and we obtain the patient's consent, where necessary. We indicate to the patient that we will be writing a letter to her that outlines what was discussed in the initial and final meetings. This letter does not go into assessment details but does clearly outline the recommendations. We ask her if we should send it to her alone or send a copy to her parents as well—it is her choice. The reason for the letter, we explain, is that she, as a health care consumer, has invested her time in the consultation and we think it important that she have her own record of the meetings and recommendations.

Evaluating the process

The success of the process used at BC's Children's Hospital can be seen in the number of patients who return and become engaged in treatment, and in the satisfaction of patients and families. While we have not yet analyzed the data from the patient/family satisfaction questionnaires, our sense is

that this consultation process is very successful for both parties. It is rare that patients do not return for treatment, and the patient/family satisfaction questionnaires completed to date indicate a high degree of satisfaction with this consultation model. We would highly recommend that health care professionals adopt the principles and strategies outlined here in their work with eating disordered adolescents and their families.

Competing interests

None declared.

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