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Review article

The Role of the Pediatrician in Family-Based Treatment for Adolescent Eating Disorders: Opportunities and Challenges

Debra K. Katzman, M.D. [a,*], Rebecka Peebles, M.D. [b], Susan M. Sawyer, M.B.B.S., M.D. [c], James Lock, M.D., Ph.D. [d], and Daniel Le Grange, Ph.D. [e]

[a] *Division of Adolescent Medicine, Department of Pediatrics, Hospital for Sick Children and University of Toronto, Toronto, Ontario, Canada*
[b] *Craig Dalsimer Division of Adolescent Medicine, Department of Pediatrics, Children's Hospital of Philadelphia, Perelman School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania*
[c] *Department of Paediatrics, Centre for Adolescent Health, Royal Children's Hospital, University of Melbourne, Murdoch Children's Research Institute, Melbourne, Australia*
[d] *Department of Child Psychiatry and Pediatrics, Stanford University School of Medicine and Lucile Packard Children's Hospital, Palo Alto, California*
[e] *Division of Child and Adolescent Psychiatry, Department of Psychiatry and Behavioral Neuroscience, University of Chicago, Chicago, Illinois*

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A B S T R A C T

Empiric research supports that family-based treatment (FBT) is an effective treatment for adolescents with eating disorders. This review outlines the role of the pediatrician in FBT for adolescent eating disorders, specifically focusing on how pediatric care changes during treatment, and discusses current challenges and misconceptions regarding FBT. Although FBT introduces unique challenges to pediatricians trained in earlier eating disorder treatment approaches, effective support of the approach by pediatricians is critical to its success.
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IMPLICATIONS AND CONTRIBUTION

The role of the pediatrician in FBT is to be a consultant to the parents and primary therapist, offering medical assessment and treatment and providing guidance and feedback that support this evidence-based treatment.

This review describes the role of the pediatrician in family-based treatment (FBT) for adolescent eating disorders (EDs) (anorexia nervosa [AN] and bulimia nervosa [BN]), outlining how pediatric care changes during treatment, and discussing current challenges and misconceptions regarding FBT [1]. Empiric research affirms that FBT, sometimes referred to as the Maudsley approach, is an effective treatment for adolescents with EDs and protective against relapse, particularly in AN [2–7]. FBT is based on the reasoning that the adolescent is embedded in the family, and therefore, parental involvement in therapy is vital to therapeutic success [8]. A fundamental tenet of FBT is that parental strengths can be harnessed to effectively change ED behaviors in adolescents. Mobilizing and empowering parents (used here to refer to the primary caregiver[s]) as principal resources is a central philosophy distinguishing this approach from other family and individual therapies [9–11].

The pediatrician (used here to refer to any clinician who provides medical care for an adolescent) is essential to the work of patients, families, and members of the clinical team. This review concentrates on the role of the pediatrician in FBT in adolescents with AN, although the role of the pediatrician is similar in adolescents with bulimia nervosa (Figure 1). Changes to the roles of all team members are recognized [12] but are beyond the scope of this article.

Review of the Literature

A paradigm shift

EDs are serious mental illnesses with the potential for life-threatening complications and death [13,14]. Until recently, treating an ED was seen as the task of the specialist team and the patient,

* Address correspondence to: Debra K. Katzman, M.D., Hospital for Sick Children, 555 University Avenue, Toronto, Ontario M5G 1X8, Canada.
E-mail address: debra.katzman@sickkids.ca (D.K. Katzman).

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with parents playing only a secondary role. This treatment strategy assumed that parents are typically not helpful agents of change and may display their own psychopathology that is to blame for the genesis of the disorder, which renders them unsuitable to help their offspring recover [15–20]. Traditional treatment strategies focus on long inpatient stays to achieve weight restoration [21,22] followed by individual supportive psychotherapy and nutritional counseling with regular monitoring of weight and physical health. The efficacy of inpatient or residential treatment for AN is mixed [23–25]. Despite weight gain, many patients lose weight after discharge and require readmission in a revolving cycle of inpatient and outpatient care [15,25]. Systematic studies of inpatient treatment have not demonstrated long-term benefits over outpatient treatment [26,27].

FBT approaches the family without blaming the parents or patient, or labeling the family system as dysfunctional [11,28,29]. This treatment has emerged in parallel with the growing literature supporting neurobiological and genetic correlates in the development of EDs [30–33], calling into question previous notions that EDs develop as a result of control struggles or family discord. Rather than dwelling on possible causes of the ED, FBT focuses on moving forward from the disease [29]. Family conflicts are presumed to result from the ED's interference rather than being responsible for it. FBT defers working on conflicts or dilemmas not directly related to the ED, and instead deals with the immediate challenge of eating [1].

FBT is often not what most pediatricians are taught to understand as "therapy", and the approach may feel counterintuitive to those trained to support adolescents' emerging autonomy. Issues around therapeutic confidentiality are still critical in FBT. However, the meetings between the therapist and the adolescent are usually brief and the therapist explains to the patient that any behavior that puts his or her life at risk (e.g., suicidality or dangerous ED behaviors such as purging or laxative use) will be shared with their parents. This stance is coached within the framework of the collective efforts of the adults who are supporting the adolescent in his or her struggle against the ED.

FBT is more comprehensible when reframed within an understanding of pediatric EDs. FBT therapists help parents learn to externalize the illness from their child, and recognize that adolescent physiologic, psychological, and social development is arrested by the ED [28,34]. The adolescent with an ED is not able to make the best choices with respect to eating behaviors, and needs the parents' help to get back on track so that adolescent individuation can take place without interference from the ED. FBT acknowledges parental expertise with their own adolescents. It positions parents as key members of the treatment team, mobilizing them to understand that the ED is life-threatening and needs full parental focus to achieve remission. The parental role is to facilitate normal adolescent development by liberating the child from the ED. Once successful, parents return age-appropriate control over eating to the adolescent and support normal adolescent development [1,9–11]. The clinical efficacy of FBT in adolescents with ED has been evaluated [5,7,10,28,35–41], and is now considered first-line treatment.

Discussion

Pediatric care in treating adolescents with EDs and FBT

The pediatrician's role begins with helping establish an ED diagnosis, including consideration of alternative explanations for weight changes or abnormal eating attitudes and behaviors (Figures 1, 2). Assessment of psychiatric comorbidities (e.g., depression and anxiety) may also fall within the pediatrician's role, although specific management of these is generally not immediately necessary within FBT unless the patient is suicidal or at risk of running away. Thorough clinical examination is always indicated to identify acute and chronic medical complications. At assessment, the pediatrician determines whether the patient is sufficiently safe to undertake outpatient treatment, or whether admission is indicated because of lack of physical and/or emotional safety. If required, admission is perceived as a brief intervention to achieve medical safety such that the patient can continue with outpatient care. It is often the pediatrician, whether as part of a multidisciplinary team or as a community-based provider, who communicates the diagnosis to the family, reinforces the seriousness of the condition, recommends FBT as a preferred treatment approach, and identifies an FBT clinician [1,14,29,42].

Key concepts for the pediatrician involved in FBT

In FBT, the pediatrician functions as a consultant to the parents and primary therapist, offering guidance and feedback (Figure 2). The pediatrician does not direct care unless there are immediate safety concerns. This is a fundamental difference in team structure, requiring humility on the part of the physician, and a willingness to defer to the parents and primary therapist on many patient care issues, even those that seem medical. For many pediatricians, this is not what they understand as treatment for an ED, because they typically anticipate more directive interaction. Likewise, most parents initially prefer to leave the treatment decisions to the doctor; the pediatrician's role in FBT is to provide information that builds parents' confidence and helps them to make informed treatment decisions [28,43]. Pediatricians not comfortable deferring to parents about decision making may struggle in this role [42]. Remembering that the success of FBT lies in empowering parents to make decisions in their adolescent's best interest can build physician comfort [36].

The pediatrician supports the therapist by providing timely reports on the patient's medical status, clinical observations of the family during examinations, and relevant information about the patient that the therapist can use in treatment (e.g., medical test results). Likewise, the therapist should communicate the goals and progress to the pediatrician. Mirroring FBT terminology during pediatric visits is helpful. One example of this is to always refer to "the ED" as being separate from the patient. When parents are frustrated, remind them that it is the ED that is challenging them and that they should therefore focus on combating the ED and not their child. Another example is to reflect treatment-related questions back to the parents and therapist. When a parent asks about physical activity, calorie intake, or weight goals, the pediatrician might respond by saying, "You know your child best. What do you think he or she needs? What solutions have you considered? Have you discussed this in therapy? It sounds like it would be worthwhile". Although it is quicker for the pediatrician to provide direct recommendations ("I think your daughter is ready for more activity", or "Your son needs an extra snack daily"), it is important to support parents to arrive at their own solutions in caring for their child.

Parents work directly with the FBT therapist around commonsense decisions about nutrition and physical activity, with pediatric consultation when needed. If the pediatrician

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