



Review article

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

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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,

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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

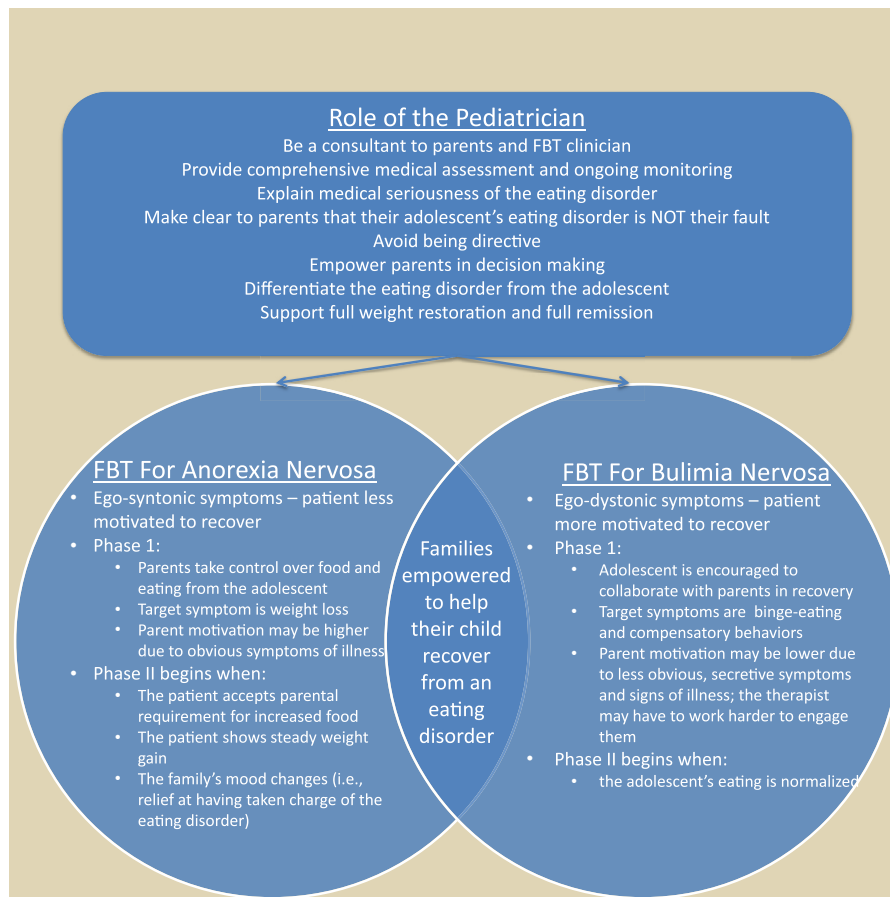


Figure 1. Family-based treatment for AN versus BN.

identifies a medical issue that requires intervention or hospitalization, she/he is obliged to provide relevant information and recommendations to the patient, the parents, and the primary therapist. Pediatric visits occur much less frequently once the

patient starts to make progress with weight gain, whereas therapy visits will continue regularly.

Pediatricians typically receive little training on how to work therapeutically with adolescents and families simultaneously. Doing this respectfully, without undermining normative parental authority, and while still acknowledging adolescent developmental autonomy, may require pediatricians to develop new skills. Giving treatment recommendations to adolescents alone without involving parents can undermine the FBT process. It is therefore imperative that pediatricians supporting adolescents in FBT involve parents at office visits. Beyond the ED, the health needs of adolescents should be managed as usual.

Family-based treatment is structured into three delineated phases with distinct goals (Tables 1–3). The pediatrician's role varies during each phase and contributes differently to the success of treatment during this process.

Phase 1: restoring the patient's weight. Healthy eating and weight restoration are key goals of FBT, because malnutrition must be reversed to improve behavior and gain insight (Table 1, Figure 2). The patient needs to understand that physical health and weight restoration are not negotiable, and that the pediatrician and parents will work together to ensure this [29].

Typically, the pediatrician and dietician collaborate to determine the weight goal. Within FBT, one of the strongest predictors of success is adequate, early weight gain (usually the first 4 weeks) [44]. Aligning parents with this goal correlates with

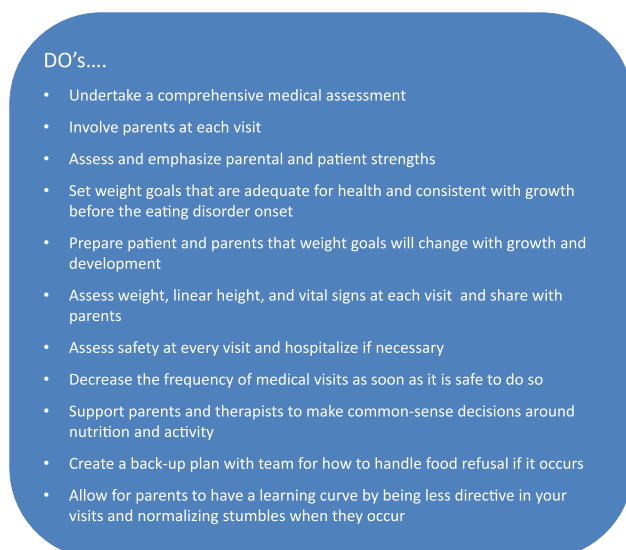


Figure 2. Pediatricians "to-do's" when supporting FBT.

Table 1

Outline of therapeutic goals and interventions: Phase 1

Phase 1: Weight restoration
Session 1 There are three main goals for Session 1: <ul style="list-style-type: none"> – To engage the family in the therapy. – To obtain a history of how anorexia nervosa is affecting the family. – To obtain preliminary information about how the family functions (i.e., coalitions, authority structure, conflicts). To accomplish these main goals, the therapist undertakes the following therapeutic interventions: <ol style="list-style-type: none"> 1. Weighs the patient. 2. Greets the family in a sincere but grave manner. 3. Takes a history that engages each family member in the process. 4. Separates the illness from the patient. 5. Emphasizes the seriousness of the illness and the difficulty in recovering. 6. Charges the parents with the task of weight restoration. 7. Prepares for the next session's family meal and ends the session. Session 2 There are three major goals for Session 2: <ul style="list-style-type: none"> – To continue the assessment of the family structure and its likely impact on the ability of the parents to help the child successfully gain weight and eat normally. – To provide an opportunity for the parents to experience success in helping the child eat normally and gain weight. – To assess the family's strengths and weaknesses, specifically during eating. To accomplish these goals, the therapist undertakes the following interventions during this session: <ol style="list-style-type: none"> 1. Weighs the patient. 2. Takes a history and observes the family patterns during food preparation, food serving, and family discussions about eating, especially as it relates to the patient. 3. Helps parents convince the child to eat more than she is prepared to, or helps to set parents on their way to working out how they can best go about normalizing eating and promoting weight gain. 4. Aligns the patient with siblings (if there are siblings) for support outside mealtimes. 5. Closes the session. Sessions 3–10 There are three goals for these treatment sessions: <ul style="list-style-type: none"> – To keep the family focused on the eating disorder. – To help the parents take charge of their child's eating. – To mobilize siblings to support the patient. To accomplish these goals, the following interventions will be appropriate to consider during the remainder of treatment for Phase 1: <ol style="list-style-type: none"> 1. Weigh the patient at the beginning of each session. 2. Direct, redirect, and focus the therapeutic discussion on food and eating behaviors and their management until food, eating, and weight behaviors and concerns are relieved. 3. Discuss, support, and help the parental dyad's efforts at promoting weight restoration. 4. Discuss, support, and help the family to evaluate efforts of siblings to help their affected sibling. 5. Continue to modify parental and sibling criticisms. 6. Continue to distinguish the adolescent patient and his or her interests from those of anorexia nervosa. 7. Review progress with the family. These interventions can be applied in Sessions 3–10 in any order, with their momentary applicability or appropriateness determined by the family's response to the initial interventions (Sessions 1 and 2). For the purpose of clarification, however, a description of each goal is outlined separately, even though in practice they may overlap to a considerable degree. Patients may require a range of sessions for completion of Phase 1, sometimes as few as two or three additional sessions, to as many as 10 or more.

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treatment success [11,34]. In addition, pediatricians are key members of the team when it comes to assessing linear growth. If patients grow taller, their goal weight will often need to be

readjusted; it is helpful to remind both patients and parents that goal weights during adolescence are moving targets that will change with growth in height and development [42,45].

Prescribed meal plans are not used in FBT; parents are encouraged to take control of meal planning and preparation [11,34], reintroduce foods eaten before the onset of the ED, and trust that they know how to feed their child. This helps introduce food exposures which, although ultimately reduce anxiety, may initially be challenging [46]. Parents often feel great distress about pushing their ill child to eat more when it is such a struggle [47]; pediatricians can support parents to more effectively re-feed their children by reminding them that although eating more is certainly better than eating nothing, they cannot settle only for "more" if weight is not being sufficiently gained. Patients need however much energy they require to reverse their malnourished state, whether this is 2,800 or 4,500 calories a day. Pediatricians can have a useful role by supporting the therapist's efforts in helping parents understand that different patients need varying amounts of food to gain weight, and that adolescents with EDs can require surprisingly high-energy diets to gain weight [48,49].

When FBT progresses uneventfully, the pediatrician's role is primarily to monitor and communicate with the patient, family, and FBT clinician about resolution of physical complications, and to reinforce the value of FBT. Pediatric visits occur much less frequently once the patient starts to gain weight, whereas therapy visits will continue regularly. If behaviors worsen or weight gain is inadequate, or especially if there has been weight loss, the pediatrician determines whether hospital admission is required for patient safety. If there are struggles, the pediatrician should underscore the severity of the ED, the importance of weight gain to recovery, and thus the value of FBT. If hospital admission is required for medical safety, discharge is usually indicated once patients are medically stable. Pediatricians can help parents to view the admission as a medical safety net rather than failure by them or their child. Outpatient follow-up appointments with their FBT clinician should be scheduled within 1–2 days of discharge to support parental empowerment during this phase.

Pediatricians can help reduce parental guilt and blame [28,43]. Many websites, books, and professionals still assert (or imply) that parents must have done something to cause the adolescent's illness. Siblings may also feel responsible [50]. Pediatricians may underestimate how powerful it can be to simply and clearly affirm that parents are not to blame.

Pediatricians can also be effective advocates for parents as they work to support their child's education during treatment. Communicating the impact of the ED on education, and providing letters of support for parents to take time away from work and for patients if they need to miss school are all part of the pediatrician's role.

During Phase 1, adolescents may display a range of worrying behaviors that can confuse parents about whether they should continue with FBT. Although these behaviors must be taken seriously and quickly assessed, they are usually a desperate fight to interfere with parents' efforts to feed the adolescent and keep them safe from the ED. These behaviors can be bewildering to parents. Some may believe that their child seems worse now that they are in treatment, and develop concerns that FBT is not the right fit for their family [47]. Preparing parents for this scenario, and reminding them that most concerns voiced by patients in Phase 1 are actually the result of ED cognitions rather than of

Table 2

Outline of therapeutic goals and interventions: Phase 2

Phase 2: Transitioning control of eating back to the adolescent
<p>The major goals of Phase 2 treatment are:</p> <ul style="list-style-type: none"> – To maintain parental management of eating disorder symptoms until the patient shows evidence that he or she is able to eat well and gain weight independently. – To return food and weight control to the adolescent. – To explore the relationship between adolescent developmental issues and anorexia nervosa. <p>To achieve these goals, the therapist needs to undertake the following interventions:</p> <ol style="list-style-type: none"> 1. Weigh the patient. 2. Continue to support and assist the parents in management of eating disorder symptoms until the adolescent is able to eat well on his or her own. 3. Assist the parents and adolescent in negotiating the return of control of eating disorder symptoms to the adolescent. 4. Encourage the family to examine relationships between adolescent issues and the development of anorexia nervosa in the adolescent. 5. Continue to modify parental and sibling criticism of the patient, especially in relation to the task of returning control of eating to the patient. 6. Continue to assist siblings in supporting their ill sibling. 7. Continue to highlight the differences between the adolescent's own ideas and needs and those of anorexia nervosa. 8. Close sessions with positive support. <p>Although the treatment goals are the same for all necessary sessions of Phase 2, the emphasis of each session changes as one moves toward the end of this phase. For example, sessions may start out similar to those of Phase 1, with weight gain as the primary goal, but the emphasis will shift toward weight maintenance as control over eating is handed back to the patient. Finally, the therapist will begin to focus more on adolescent issues as the patient makes a transfer from Phase 2 to Phase 3.</p>

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patients themselves, can help parents separate their child from the disease, and focus the fight against the ED rather than the adolescent. Patients often seem worse before they recover; these behaviors usually reduce in frequency as long as parents stay calm and consistent in their limit setting. Pediatricians can model this by refusing to escalate when the ED causes adolescent behaviors to intensify, and by supporting parents' plans to intervene with the ED even when the adolescent is angry.

Parents and providers alike are typically unpopular with the patient early in FBT. This does not mean that any member of the team is incorrect or unskilled. Treatment decisions are being made for the adolescent's health and safety, not as a punishment. Patients often feel angry and upset early in treatment because they feel they are not being listened to and their preferences are not being heard. This can be difficult for pediatricians to navigate. Reframing this as the disorder that is not being heard or negotiated with, rather than the adolescent, can be helpful; the adolescent's autonomy has been usurped by the ED and the parents are working hard to make the "ED voice" softer and the voice of the adolescent louder [34]. When presented with an adolescent who raises legitimate concerns and frustrations about FBT, it is understandable to make the mistake of aligning with the ED, which disempowers the parents. Instead, pediatricians can be most effective if they remain neutral with the patient, and give feedback to parents and/or the therapist if there are any true concerns that need to be worked through in treatment [28].

During Phase 1, it is also common for patients to feel that their therapist does not understand them. Caring pediatricians will

Table 3

Outline of therapeutic goals and interventions: Phase 3

Phase 3: Adolescent issues and termination
<p>The major goals for Phase 3 treatment are:</p> <ul style="list-style-type: none"> – To establish that the adolescent-parent relationship no longer requires the symptoms as an idiom of communication. – To review adolescent issues with the family and to model problem solving of these types of issues. – To terminate treatment. <p>To accomplish these goals, the therapist undertakes the following interventions:</p> <ol style="list-style-type: none"> 1. Reviews adolescent issues with the family and models problem solving of these types of issues. 2. Involves the family in review of issues. 3. Checks on how much the parents are doing as a couple. 4. Delineates and explores adolescent themes. 5. Plans for future problems. 6. Summarizes the session. 7. Terminates treatment.

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often hear adolescents voice this concern as well as concerns that the child's parents are not listening to them. Under these circumstances, pediatricians may inadvertently undermine FBT by trying to be the one person who listens to the patient and advocates for them; it is easy for pediatricians to be lured into trying to rescue patients from the FBT process. Pediatricians should remember that the parents and the therapist are also listening to the adolescent. The pediatrician should assess his or her own counter-transference during this process, and understand that most parents are trying to do the best for their child. Working with parents to help the adolescent is far more effective than working against the parents during FBT [11].

It is tempting for exhausted parents (and pediatricians) to believe that referral for more intensive treatment (e.g., day treatment, residential program) would be more effective. However, these models still involve patients eventually having to return home. Although a medically unstable patient or those at risk of harm may require brief hospitalization, it is unlikely that a higher level of care will improve treatment success. A pediatrician who suggests a change in treatment model in the midst of FBT risks undermining parents at the critical time of initiation of treatment by making them feel that another facility would be more expert in managing their child. One of the most important roles of pediatricians at this time is to support parental confidence as they engage in this difficult work [43]. Pediatricians can reframe these thoughts by reminding parents that home-based FBT has shown greater long-term efficacy than other treatment models. It can also help by reminding parents that no treatment model is perfect, but that in the end patients have to come home, so working through difficulties in the home setting is best as long as all members of the family are safe.

In the past, the ED field has accepted metrics of recovery that were arguably metrics for being less ill rather than true metrics of being disease-free and well. Goal weights were often set too low. For instance, reaching 90% of an expected body weight or achieving the onset or resumption of menses was commonly considered acceptable [51–53]. Whereas there is ongoing debate about the question of what a healthy weight is, recent evidence suggests that the return of menses in adolescents after FBT occurs at 95% of expected body weight [54].

EDs were often conceptualized as chronic illnesses that would not fully remit but would remain a lifelong struggle. Although not all patients reach full remission, more than 50% of adolescents treated with FBT do [7]. Pediatricians can remind parents and patients that full remission is the goal, emphasizing the importance of fighting the disease effectively in the early stages, reaching a healthy weight, resuming pubertal development, reversing medical complications, and restoring normal cognitions. FBT asks parents not to settle for anything less.

Phase 2: negotiating a new pattern of relationships. The role of the pediatrician changes during Phase 2 because the medical vulnerability of the patient has significantly reduced (Table 2). Still, parents can become exhausted during Phase 1 and can become impatient for the adolescent to resume developmentally appropriate activities and autonomy at meals. This is understandable, because being in charge of all meals, activities, rest periods, and food choices for an adolescent with an ED requires tremendous commitment of time and energy, and can contribute to parents feeling socially isolated with little time for self-care. Therefore, this can be a high-risk time for parents if they lose their determination to achieve complete remission. Pediatricians can have a key role in reminding parents that it is critical to the patient's future health that he or she reach the goal weight, that they do not settle for less, and that feeling weary or discouraged during treatment is normal and does not mean that the treatment will not be successful.

Phase 3: adolescent development and treatment termination. During Phase 3, pediatric care typically continues with a focus on less frequent medical monitoring (usually monthly or bimonthly) of growth, pubertal development, and other ED-related medical issues (Table 3). The pediatrician remains central in supporting the adolescent and parents in their efforts to achieve recovery and creating a plan for relapse prevention. When the ED is largely resolved, the pediatrician can then engage with the adolescent about other more typical adolescent behavioral issues.

Common Misconceptions About FBT

Misconceptions about the focus, content, and process of FBT by pediatricians can lead to problems in the multidisciplinary team and family. Such misconceptions can be explicitly or inadvertently communicated to other providers and families and result in clinical recommendations or decisions that are counterproductive.

FBT does not work for everyone. Data suggest that whereas most patients treated with FBT experience substantial improvement, with about 50%–60% fully recovered by 1 year after treatment, about 15%–20% do not improve at all [7]. Setting expectations too high for any treatment is unhelpful because when things do not go well (and they will not go optimally about half of the time), guilt and blame can result. Parents may feel that they have failed and pediatricians might feel they made the wrong decision in suggesting FBT. Nevertheless, to date, no other treatment is known to be as effective as FBT.

One consequence of a poor outcome is that the pediatrician may conclude that FBT only works in easy cases. Whereas FBT works well for younger patients with short duration of disease, data also suggest that FBT is more effective than individual treatment for those with increased pathology related to

obsessive-compulsive features, eating related cognitions, and binge eating and purging behaviors [55]. It is also more protective against relapse than individual therapy [7].

The assertion that FBT is helpful only in adolescents and not adults is also incorrect. Most studies have found that younger patients have a better prognosis than older ones. However, two randomized controlled trials that included young adults found no difference between those treated with FBT and other treatments [2,56]. Therefore, for some adults with AN whose families are willing, FBT is worth trying, especially if they are college-age and living at home or willing to return home during weight restoration.

FBT is not only effective in two-parent households. Although one study found that the FBT dose needed to be larger when the patient came from a single parent, divorced, or reconstituted family, children in these families ultimately did as well as those from intact families [4]. In addition, although a high percentage of family studies using FBT are in higher socioeconomic brackets, minority status, ethnic identity, culture [19], and level of education do not affect outcomes [4].

Other misconceptions relate to the process of FBT. Because early in FBT great emphasis is placed on behavioral change to promote weight gain, the approach has sometimes been misconstrued as being an exclusively behavioral intervention [1]. FBT therapists emphasize the need for parents to promote behavioral change, but the strategies used to help them are derived from family therapy interventions [57]. FBT therapists do not give out meal plans or make recommendations for behavioral management, but instead promote parental communication, alignment, and problem-solving derived from family systems therapy approaches. In addition, therapists emphasize the importance of generational boundaries and roles in the family, based on structural family therapy principles [58–60]. Therapists use externalization of the illness, a strategy from narrative family therapy [58], to help parents take charge of the situation and distinguish the adolescent from the disordered thinking of AN. Thus, although behavioral change is the target of these family therapy interventions, the approach is not exclusively behavioral, but familial [57]. Even with the separated form of FBT (in which the adolescent is not in sessions with the parents), the approach remains focused on family therapy intervention techniques [6,61]. For these reasons, it is also a misconception that someone not trained to work with families can do FBT. Effective FBT therapists understand the dynamic processes in families, the interaction of these processes with family evolution during adolescence, and their relationship to ED symptoms [1].

Some have also suggested that insistence on strong parental intervention risks permanently destroying the parent–child relationship. There is no evidence to suggest that this is a typical outcome of FBT. Instead, most adolescents report that although it was difficult for them to temporarily yield control over eating to their parents, they recognize its importance to their recovery [62–64]. The goal of parent control in FBT is circumscribed to those areas that maintain the ED, such as food, eating, and exercise. FBT therapists would not support a blanket parent-takeover of an adolescent's life. By limiting parent control to this area, therapists emphasize that the focus is not on limiting adolescent autonomy, but on limiting the impact of the ED on the adolescent. In addition, FBT does not end once weight restoration is accomplished. Instead, the emphasis in the second and third phases of FBT is about

adolescent self-management, with the aim of getting adolescents back in control of their lives in an age-appropriate manner.

Another common misperception about FBT is that the therapist does not have a therapeutic relationship with the patient. A pediatrician who believes this to be the case may be tempted to suggest individual therapy to support adolescent autonomy. Adding individual therapy during FBT typically confuses families about which type of treatment is primary, makes it more difficult to maintain healthy eating behaviors, and complicates coordination of care. A decision to add an individual therapist should therefore be made cautiously and on sound clinical grounds (e.g., when a comorbid condition such as severe panic attacks or severe obsessive compulsive disorder warrants immediate intervention). When individual therapy is added to FBT, care should be taken to ensure that parents understand that the purpose of individual therapy is not to directly treat the ED; the impetus for changing the child's eating related behaviors remains firmly with the parents.

FBT develops and supports the therapeutic relationship with the adolescent in the context of family work; however, every session begins with the therapist meeting briefly with the adolescent individually, weighing him or her, and discussing the past week's events [1]. The therapist offers to help the adolescent voice challenges that can be brought up with the whole family. During family sessions, the therapist actively engages the adolescent in the process and uses an understanding of adolescence and EDs to help the patient not feel guilty or blamed for being ill. In the second and third phases, the therapist helps the adolescent to be even more active in family work by suggesting ways that the parents can be most helpful in transitioning control and supporting adolescent development. A number of studies suggest that adolescents have a good therapeutic relationship with the therapist in FBT, even early in treatment, and view them as helpful [62,63].

Advocating for Family-Based Treatment

FBT is not available in many geographic areas. In addition, relatively few therapists are trained and certified in this treatment. Pediatricians can be important advocates, supporting the dissemination of evidence-based treatments for EDs and promoting the training of FBT therapists in their communities [65]. Pediatricians can also educate schools and communities about the important role parents have in treating their child with an ED.

Whereas the details of the pediatrician's role in FBT will differ slightly in a hospital-based multidisciplinary team versus a community-based practice, the principles are the same. The major difference for pediatricians within FBT is not what is required of them in terms of the medical role, but rather, what is not required. In particular, it is how the medical role is executed that differs so dramatically when collaborating with an FBT clinician. FBT offers both pediatricians and therapists highly satisfying opportunities to help patients and families recover from EDs.

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