The Role of the Generalist in the Initial Treatment of Adolescent Anorexia Nervosa

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Anorexia nervosa is a potentially serious illness characterized by the sufferer having a malignant fear of gaining weight and being fat. It was believed to stem from psychosocial problems. Treatment of the adolescent with anorexia has typically involved an inpatient stay in a specialized center where he or she can receive therapy aimed at changing thinking and exploring family dynamics. A newer strategy, family-based treatment, focuses on the young person’s physical state. It can be initiated by a primary care physician during an outpatient visit. This article introduces this new paradigm for treating anorexia nervosa in adolescents and outlines the role of the primary care physician in diagnosing, treating and supporting the patient.

Eating disorders are potentially serious mental illnesses in which an individual has a malignant fear of gaining weight and being fat. These conditions can have life-threatening complications and are the most lethal of mental health problems in adolescents.1 Even so, physicians historically have not given them the same level of attention that they have other illnesses, and many feel they lack the knowledge needed to treat a patient with an eating disorder. Thus, when a young patient presents with the symptoms of anorexia nervosa or a parent suggests their child may have the problem, many physicians believe they need to immediately refer the patient to a specialized program without beginning therapy.

Newer thinking suggests that primary care physicians have an important role to play in helping young patients with anorexia. They can introduce family-based treatment (FBT), which focuses on weight restoration. Sometimes referred to as the Maudsley Method, FBT has been shown to be effective as an initial treatment of anorexia and for preventing relapse.2 The conversations required to introduce it and support the family as the patient progresses through treatment are comfortably within the primary care or generalist physician’s usual scope of care. Thus, physicians need not delay starting treatment while their patients await specialty care.

This article describes the use of FBT for anorexia nervosa and outlines the role primary care physicians can play in introducing it.

The Old and New Paradigms

The medical community has long assumed that treatment of eating disorders is best provided by specialists, often in inpatient settings. This thinking is not surprising, given that eating disorders have long been viewed as a psychological problem stemming from family dynamics. In fact, Sir William Gull, who named anorexia nervosa in 1873, said, “The patients should be fed at regular intervals, and surrounded by persons who would have moral control over them; relatives and friends being generally the worst attendants.” Jean Martin Charcot was no more charitable when he endorsed separating the patient from their father and mother, “whose influence, as experience teaches, is particularly pernicious.” These observers assumed that psychopathology in the family contributed to or caused anorexia; thus, separating the patient from the parents’ control was believed to be necessary to restore health. Treatment systems built on such thinking are characterized by extended inpatient stays aimed at restoring nutrition.3 The generalist physician’s job was only to refer the patient to a specialized program without beginning therapy.

Research has since demonstrated the limited benefit of this approach, as many inpatients lose weight after discharge and are subsequently readmitted.4
Certainly, psychosocial factors play some role in causing eating disorders—up to a 41% contribution, according to studies of covariance. But even before they develop disordered eating, many who are subsequently affected are noted to have had goal-directed personalities. The success they’ve felt making and meeting one weight-loss goal, and then the next one, is reinforcing. The eating disorder is considered “ego-syntonic” or satisfying rather than “ego-dystonic” and isn’t identified as being maladaptive. In fact, many adolescents with anorexia are at least mildly anxious at baseline. The loss of energy induced by starvation paradoxically reduces their anxiety and can, therefore, become a relief.

It would be reasonable to expect that addressing the patient’s anxiety or maladaptive behaviors through counseling might be of benefit, as counseling clearly is effective for treating other eating disorders. But that is not the case with anorexia. Studies of cognitive behavioral and dialectical therapy, group and individual therapy, or inpatient versus outpatient treatment for adolescents with anorexia have consistently shown these approaches fail at similar rates. Only FBT seems to show success, at least over the short term.

That an individual’s physical condition affects their cognition and behavior is both common-sensical and, as it applies to eating disorders, supported by a growing number of studies. Perhaps the first to show the effects of disordered eating on mental state was the landmark starvation study done at the University of Minnesota during World War II. Conscientious objectors to military service were recruited to help researchers determine the nutritional requirement for soldiers and generate nutritional recommendations for eastern Europeans suffering from war-related malnutrition. Healthy and “well-adjusted” male volunteers were fed a diet designed to induce a 25% weight loss over a 12-week period. After several days of caloric restriction, irritability and loss of concentration were observed. Over a period of weeks, the men went on to develop sleep irregularities, overt mood disorders and even psychosis; one man cut off three of his fingers in an apparent attempt to be removed from the study. Upon refeeding, some of them described a fear of weight gain similar to the fear described by sufferers of anorexia. The treatment for their starvation-induced psychiatric disorders was food, and all of the symptoms resolved after nutrition was restored.

With these ideas in mind, some postulated that eating disorders might cause or exacerbate psychosocial issues rather than be caused by them. They proposed that the physical problem—starvation—needed to be corrected before the patient’s psychosocial problems could be addressed.

The Gist of Family-Based Treatment

Family-based treatment has been shown to be effective for young people with anorexia and is now considered a first-line treatment. It assigns no blame for the circumstances that preceded starvation, focusing instead on a route forward for the family. It assumes that an adolescent’s expected biopsychosocial development has been arrested or partially reversed by starvation and that providing adequate nutrition will correct or minimize their emotional distress and begin to improve intra-familial dynamics.

The parents’ job is to facilitate the return to normal development by freeing the child from the eating disorder as they direct refeeding. Only after nutrition is restored does the adolescent regain autonomy, and only after nutrition is restored can pre-existing or comorbid psychiatric or intra-familial conflicts be addressed through counseling. In some cases, nutrition alone (without follow-up counseling) is enough to fully restore a patient’s function.

In FBT, family members are coached to “externalize” the eating disorder, naming it as if it were an undesirable second personality wholly separate from the adolescent. In the early phase, parents are counseled about the immediate barriers to adequate caloric intake and how to address eating disordered behaviors as if they were an unwanted houseguest, with polite-but-consistent firmness.

Refeeding is accomplished using a strategy referred to as “the Magic Plate.” Parents choose the adolescent’s foods and portion sizes without input or help from the adolescent; the pre-arranged plate magically appears, and the teen is expected to eat all of the food. Calorie-dense foods are chosen, providing the (possibly massive) energy required for a return to health without the discomfort that could arise if larger volumes of food were introduced to a shrunken gut. If the patient asks about ingredients or menu alternatives, their inquiries are met with brief, vague answers such as “This food has just what you need.” Failure to eat all that is provided triggers a loss of the next day’s exercise privileges or some similar consequence constructed by the family. Expectations about the timeliness of a meal’s consumption also can be put into place: For example, the parent might say, “Life resumes after you eat.” Rebellion is met with calmness. One parental support group suggests parents tell themselves, “I am a brick wall,” so as not to allow the intensity of the situation to escalate.

In many cases, by not having to plan the next meal or to count calories the patient feels as if a heavy psychic burden has been lifted, and FBT is perceived as freeing rather than constraining. As nutrition improves, patients tend to become less resistant to feeding, and the family’s mood relaxes. Once weight is restored, a therapist leads the family back toward allowing the adolescent to manage their own food intake and exercise schedule. Circumscribing parental control to eating and exercise during the initial phase of treatment, rather than allowing them to take over all aspects of the adolescent’s life, eases this process. Reintroducing previously avoided foods such as desserts or stressful food-related situations while the parents retain control of the rest of the
teen’s calorie balance can minimize anxiety about the transition back toward independence.28

The Office Visit
The primary care physician’s first task is to recognize anorexia. The diagnosis is sometimes suggested by a family member out of concern for their loved one, but it can be masked. For example, anorexia may not be diagnosed as promptly in someone who is or has been overweight as it would be in someone who starts from a normal or thin habitus.29 Rather, obese or overweight individuals are often rewarded or congratulated for their efforts to lose weight, to their eventual detriment. This delay in diagnosis can allow obesogenic or manipulative behaviors to become firmly established and the biophysical consequences of starvation to deepen.30 In almost no case is it appropriate for a child to lose weight; at most, weight can be held while growth occurs. Because weight-control interventions in primary care settings have not been shown to be effective31 and may cause harm,32 any weight loss in an adolescent should prompt consideration of an eating disorder.

The physician must consider a differential diagnosis of weight loss, which might include esophageal motility problems, reflux or ulceration, or substance abuse.33 Additional psychiatric comorbidities must be considered and, depending on the physician’s level of comfort, addressed concomitantly with the anorexia. However, it must be noted there is no reliable pharmacologic treatment for anorexia.

During the assessment, the clinician determines whether it is safe for the patient to be treated as an outpatient. Suicidality or extreme malnourishment with milder electrolyte abnormalities does not necessarily preclude outpatient FBT. If hospitalization is required, however, it should be short and focused on medical safety; full refeeding needs to happen at home.

Once a diagnosis is made, the physician needs to explain FBT and the critical importance of refeeding to the family or to the parents alone and offer them resources (see box). Whether to include the patient in the discussion is a decision that should be made on a case-by-case basis. It is reasonable to tell the family to aim for an average weight gain of 1 to 1.5 pounds per week. Expectations for the duration of refeeding must be managed; parents should be told refeeding may take as long as a year.

Perhaps the most serious mistake a physician can make is to partially treat the anorexia by failing to restore the adolescent to their previous or expected weight as identified by pre-illness growth curves, even if their pre-illness weight was above the 50th percentile for their height.34 (Note that weight targets may need to be adjusted as the adolescent grows.) For girls, return of menses, which often requires 95% or more of expected (not ideal) body weight, may be an appropriate early goal.26 Complete remission of the eating disorder behaviors with return of pubertal development, reversal of medical complications and restoration of normal cognitive patterns are the ultimate goals of therapy.

Once the family commits to FBT, the physician’s job is to provide them with support and help them build confidence.

Because some still assert or imply that parents must have done something to cause the adolescent’s illness, clinicians might underestimate how powerful their affirmation is that parents are not to blame and how important it is to honor their efforts and encourage them to generate their own solutions as problems arise. Using counseling phrases during a clinic visit can be useful; a good example is referring to “the eating disorder” as being separate from the patient, or reminding parents that they may be growing frustrated with the eating disorder and not with their child. Physician visits might become infrequent once the patient starts gaining weight.

It is important that well-meaning clinicians not undermine FBT and allow the premature return to freedom of nutritional choice.35 Emotionally attuned clinicians who would normally strive to honor the autonomy of the adolescent might find the feeding style unusual or be uncomfortable with it. They must instead assume that the adolescent has become unable to make good nutritional choices and needs the firm intervention of the parents in making those choices for them, mimicking a much earlier stage in their life.

Conclusion
Primary care physicians are often the first to identify mental health concerns in children and adolescents. With appropriate specialty support, they often can treat depression, anxiety, ADHD and other conditions with medications. Primary care clinicians also can and should identify anorexia nervosa in young patients and should not hesitate to address it while any needed specialty care is pending. The remedy for anorexia is food and parental support.

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Resources
Maudsley Parents—A volunteer organization of parents who have helped their children recover from anorexia and bulimia through the use of family-based treatment. maudsleyparents.org
F.E.A.S.T. (Families Empowered and Supporting Treatment of Eating Disorders)—An international organization for caregivers of patients with eating disorders. feast-ed.org

REFERENCES
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