Conclusions

The eating disorders anorexia nervosa, bulimia nervosa and variants typically develop in adolescent girls, but sometimes in boys. Despite a long history, the evidence base for effective treatments is weak and existing clinical guidelines are based on consensus views rather than strong research. Effective coordinated management of physical and psychological aspects of the disorders is crucial, but treatment response remains very variable, with adverse outcomes commonly extending into adulthood. Anorexia nervosa carries a high morbidity and occasional mortality and so energetic, early treatment is indicated.

Key Texts

Fairburn C. (1995), Overcoming Binge Eating, New York, Guilford Press, (ISBN 978-0898621792).

Gowers S.G. & Green L. (2009) Eating Disorders - CBT with children and young people. London. Routledge

National Institute for Clinical Excellence (2004). Eating disorders. Core interventions in the treatment and management of eating disorders in primary and secondary care. London: Gaskell.

Key Contacts and Other Resources

The UK National Eating Disorders charity, bEAT (www.b-eat.co.uk) provides information and help for those with eating disorders and their carers. Another website of interest is www.kooth.com which is aimed at young people and offers online support.

Self-help & resources for carers:

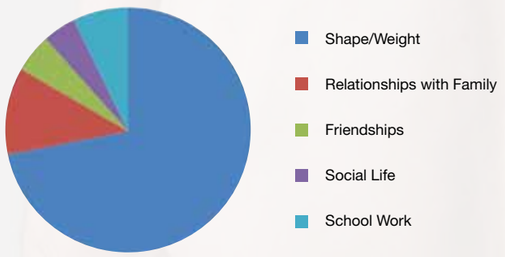
Lock J. and Le Grange D. (2005), Help your Teenager beat an Eating Disorder. New York, Guilford .ISBN 978-1593851019.

Schmidt U. and Treasure J. (1993) Getting Better Bit(e) by Bit(e): A Survival Kit for sufferers of Bulimia Nervosa and Binge Eating Disorders, London, Psychology Press, (ISBN 978-0863773228).

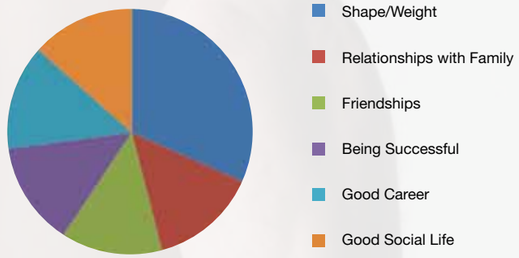
Treasure J., Smith G. and Crane A. (2007) Skill based learning in caring for a loved one with an eating disorder, London., Routledge. (ISBN 978-0-41543158-3).

Figure 1

Self-evalution pie-chart showing over-importance of weight and shape concern



A revised self-evalution - during CBT



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Adolescent Eating Disorders

Introduction

Eating disorders are a group of syndromes involving preoccupation with weight, shape and control, abnormal eating behaviour and adverse physical consequences. The most important forms are anorexia nervosa, and bulimia nervosa, though adolescents also present with other clinically significant eating disturbances, including selective eating, and other phobic and obsessional disorders, impacting on their eating and weight. Anorexia nervosa can develop from the age of around 8 years, reaching a peak at about 15-18, whilst bulimia nervosa is rare below 13, but becomes more frequent than anorexia by young adulthood. Atypical forms occur more commonly than full syndrome disorders.

Although research into anorexia nervosa has a long history, the evidence for the effectiveness of treatments, is weak. Bulimia nervosa though more recently described, has resulted in many more treatment trials, generally of better quality, but adolescent studies are lacking. Despite the shortage of research, clinical guidelines, notably the NICE guideline of 2004 give useful recommendations for good practice.

Why is this topic of importance?

- There have been a number of reports in recent years suggesting eating disorders are becoming more prevalent.
- Anorexia nervosa often blights adolescent development and carries a higher mortality rate than any other mental disorder.
- Initiating treatment early is important to improve prognosis and to limit physical risks, especially to bones, growth and the reproductive system.
- The National In-patient study of Child and Adolescent Psychiatric Services (NICAPS) showed eating disorders to be responsible for greater use of in-patient psychiatric beds in the UK than any other disorder.
- In-patient treatment, whether in the NHS or the growing independent sector, is very expensive, so anorexia nervosa is a costly condition, to the NHS budget as well as to young people and their families.

Diagnosis and Clinical Features

Eating problems encompass a whole range of difficulties from feeding disorders of infancy to the more complex, serious and life threatening conditions which present in adolescence and young adulthood which are the focus of this paper.

Eating disorders occur mainly in girls. The most important are anorexia nervosa and bulimia nervosa, but a number of atypical eating disorders share similarities, are common (particularly in early adolescence) and can also cause significant difficulties. Sometimes these atypical presentations are dominated by obsessive compulsive or mood symptoms, or they arise out of relatively common feeding disorders of earlier childhood, making differential diagnosis more difficult. They may sometimes be an expression of a battle for control (particularly with parents).

Adolescents with eating disorders suffer a number of abnormal cognitions, the one that is characteristic of eating but not childhood feeding disorders being the over-evaluation of the self in terms of weight and shape. All other personal qualities and attributes are relegated below the belief that self-worth is dependent on weight or the ability to restrict food intake in the face of hunger. Young people may sometimes describe themselves as “feeling fat” and equate this with actually being fat. In anorexia nervosa this belief system results in dieting behaviour and an intense fear of weight gain and fatness. Most of the other features are secondary to this cognition and its consequences, such as weight loss or a failure to gain expected weight, with either a delay in completing puberty or (in girls), cessation of menstruation. There is generally no loss of appetite. Weight loss is viewed as an achievement and thus young people generally have a limited desire to change.

Some engage in excessive exercising. Self-induced vomiting, misuse of laxatives or diuretics are practised by a subgroup, who may sometimes binge eat.

Poor self esteem and feelings of ineffectiveness are extremely common, depressive and anxiety features, impaired concentration and obsessional symptoms are frequently present. Social interest declines as young people lose weight and most become socially withdrawn and isolated. These psychosocial features tend to get worse with weight loss and often improve with weight regain.

In bulimia nervosa, there are attempts at weight control based on a similar preoccupation with body weight, but the person loses control of their eating as a result of hunger and a propensity to binge. Vomiting and other compensatory behaviours are then employed to avoid weight gain with the result that weight is maintained within a normal range. Typically a young person develops a characteristic cyclical pattern of missing meals in the early part of the day and binges and purges in the evening. The next day, guilt leads to renewed efforts to cut back on eating, with maintenance of the cycle. Young people with bulimia are less often perfectionistic, less socially withdrawn and may engage in more challenging adolescent behaviours such as drug and alcohol misuse. Binge eating without compensatory behaviours generally leads to obesity and rarely presents to mental health services.

In early adolescence, changes in body shape associated with puberty can make young people feel like they have no control over what is happening to them. Perfectionist young people with poor self esteem can feel they are failing in everything unless they have “control” over their eating and attain unreachable targets. Although restricting dietary intake is a coping strategy, those with anorexia are generally unhappy, fearing the potential loss of control if they stop restricting food. For those with bulimia, regular loss of control is a frightening reality.

Despite growing evidence of genetic predisposition to eating disorders, environmental factors are thought to mediate their development.

Families where a young person has an eating disorder commonly experience high levels of stress which may maintain the disorder, either through the attention it draws or from feelings of guilt generated. There is no evidence of a characteristic family type which causes eating disorders, but young people in families which place great value on diet or exercise (e.g. where a member has diabetes or coronary heart disease), may be more vulnerable.

Current Trends

- There are suggestions that eating disorders, particularly bulimic forms, are becoming more common, occur in younger children and increasingly in boys. The incidence of anorexia nervosa in females aged 15-24 years, appears to have increased significantly between 1935 and 1999, with average prevalence rates for anorexia nervosa and bulimia nervosa reaching 0.3 and 1%, respectively.
- The explanation for the increase is unclear but the societal focus on appearance which has spread to boys, the media focus on obesity and ‘healthy eating’ messages delivered in schools may unwittingly have contributed to this trend.
- This increase in prevalence is however not as great as the lay media sometimes imply. Awareness and better detection rates have probably exaggerated this apparent trend as more cases have presented to services. Only a minority of people with eating disorders, especially with bulimia nervosa, are treated in mental health care.

Challenges to Practice

Despite the attraction of school based intervention, primary prevention strategies have to date yielded mixed results. It is clear that school based interventions that mainly focus on weight and shape issues can be counterproductive and actually increase such preoccupation. Strategies to improve self-esteem, personal effectiveness and open communication may be more productive. In a similar light, widespread educational initiatives aiming to reduce obesity may stigmatise those whose weight and shape don’t fit societies expectations – validating the cognitions underlying eating disorders.

A second challenge involves clarifying the role of in-patient psychiatric care in the treatment of anorexia nervosa. Cohort and treatment trials have yielded generally poor results from an intervention which is very costly to the individual and the health economy. Particular problems arise when in-patient treatment is far from the young person’s home and when the in-patient programme is not fully integrated into an overall package of care. The majority of young people with severe anorexia nervosa fail to fully recover within two years of onset and so it makes sense to view in-patient management as merely one component of treatment rather than a complete one.

Monitoring acute physical risk (particularly electrolyte and mineral levels) during treatment is crucial as risk can increase with re-feeding. But the need for clinicians to address physical risk needs to be balanced against the adolescent’s need to negotiate independence and autonomy.

What helps?

Education and advice on normal energy requirements, healthy weights and expected growth trajectories are helpful in the initial stages of simpler problems. It is also essential to teach young people alternative coping strategies as there is a risk of using overeating or restriction as a way of dealing with stress and poor self-esteem. Supportive counselling can help deal with anxieties and worries and striking a balance between change and self-acceptance.

Established eating disorders require more specialist help. Anorexia nervosa in younger adolescents requires a family intervention with individual therapeutic work to tackle underlying beliefs about weight, shape and control. Family based treatment should help parents take control of behavioural management of their child’s eating and weight gain. It also aims to explore family factors and dynamics which might be maintaining the illness, though it tries to ensure parents don’t feel blamed for their child’s condition, adding to their own sense of guilt.

In older adolescents and young adults with anorexia or bulimia nervosa individual therapeutic work is the mainstay of treatment. As well as addressing beliefs about the importance of weight and shape including factors that led to the development and maintenance of the condition. It often focuses on mood and interpersonal relationships. Figure 1 (at end of document) illustrates how this therapeutic work may result in a more balanced self-assessment. A family intervention should be included as required.

Management is usually on an out-patient basis, with in-patient treatment reserved for severe or resistant anorexia nervosa.

Therapies aim to improve self-esteem, address fears of growing up and the responsibilities associated with it. They teach young people coping strategies, and help them develop confidence in being able to deal with changes in their body, their life and future.

In anorexia nervosa a weight gain of 0.8-1kg per week for in-patients or half that for out-patients should be aimed for, to within the normal weight range, or until hormonal functioning returns (sometimes monitored by pelvic ultrasound and DEXA x ray assessment of bone calcification).

In patient management can be required for severe physical or psychological risk. Inpatient admission may ensure restoration of weight, but this alone is not a “cure” for anorexia nervosa. In-patient treatment is not generally indicated for bulimia, for which cognitive behaviour therapy appears to confer the best results. Intensive day programmes offer an alternative to in-patient management Group work and creative therapies often feature in such programmes and communicating with other young people with similar illnesses can make them feel supported and understood. Family work is sometimes delivered as multi-family therapy, a number of families being seen intensively at the same time. This approach creatively addresses how family members support each other and make behavioural changes, particularly around meal preparation.

There is a limited role for medication in the treatment of eating disorders though there is research evidence to show that antidepressants like fluoxetine are effective in reducing binge eating and are sometimes useful adjuncts to psychological therapies in managing co-morbid depressive or obsessional features. The atypical antipsychotic drug olanzapine is sometimes used as an anxiolytic particularly when over-valued ideas border on delusional belief.

Self-help is a growing field, whether guided by a therapist, or in ‘pure’ form in which the participant works through exercises in a book or DVD. There are now a number of internet sites offering resources and discussion forums.

About 40% of young people with anorexia nervosa might be expected to fully recover within 2 years of treatment, a significant number having difficulties into adulthood. Bulimia nervosa appears to have a slightly better outcome.

Unresolved Issues

The NICE guideline drew attention to the very limited number of good quality trials of psychological therapies for anorexia nervosa (at any age) and for bulimia in adolescents. Family based therapies have the strongest evidence base in adolescents, but individual therapies (particularly CBT), have hardly been tested and the combination of individual CBT with a family intervention, not at all. The role of pharmacological agents is uncertain. The NICE guideline drew attention to the lack of effective drugs for anorexia nervosa, but there are increasing reports of their effectiveness for co-morbid features.

Implications for Practice

- Eating Disorders are complex, disabling conditions. Early intervention is indicated to reduce acute physical risk and chronicity.
- Although physical aspects such as weight loss and consequences of purging carry significant risk, interventions focussed on these (such as weight restoration), don’t on their own, effectively treat the underlying psychological disorder.
- Interventions need to provide an individual component to address motivation and cognitive features alongside a family based intervention.
- Obsessional features and mood disorders are common and suicidality should always be assessed.