The Treatment of Adolescent Eating Disorders

Notwithstanding sparse treatment data, recent efforts are beginning to provide clinicians with some clear treatment guidelines for medically unstable adolescents with anorexia nervosa.

Eating disorders (EDs)—anorexia nervosa (AN) and bulimia nervosa (BN) in particular—remain among the most perplexing psychiatric disorders. The lifetime prevalence of an eating disorder among youths (aged 12 to 18 years) in the US is estimated to be more than 6%. Despite these high numbers and the associated morbidity and mortality of these disorders, few randomized clinical trials (RCTs) (eg, psychotherapy, pharmacotherapy, or combined) have been conducted on EDs in adolescents. As a consequence, relatively little is known about efficacious treatments for this patient population.

Notwithstanding sparse treatment data, recent efforts are beginning to provide clinicians with some clear treatment guidelines. For medically unstable adolescents with AN, a course of inpatient treatment is indicated until vital sign stability is achieved. Depending on admission weight, duration of hospital stay typically does not exceed 14 days provided calorie input starts high (~ 2,000 kcal), and is advanced fast (adding 200 kcal every other day). For medically stable adolescents with AN, our best efforts demonstrate that about 50% of patients will remit at one year post treatment when receiving a course of family-based treatment (FBT). FBT is quite proficient at bringing about weight recovery for a majority of patients, although somewhat less effective at engineering the immediate remission of cognitive symptoms. Unfortunately, data for other treatment strategies have not been able to muster such encouraging evidence.

FBT is therefore the current preferred therapy albeit for a circumscribed subset of the adolescent population. That is, it is an outpatient psychotherapy implemented by mental health providers (eg, psychiatrists and psychologists) for medically stable adolescents with AN. In addition to substantial remission rates in FBT, this treatment is manualized and therefore allows the clinician clear instructions about its implementation. Briefly, FBT emphasizes parental capacity for weight restoration of their adolescent offspring, therefore supporting parent to take on the task typically done by nurses had the adolescents been admitted to an inpatient refeeding program. Once weight has been restored, the second goal of this treatment is to support the return of the adolescent to age appropriate developmental tasks.

FBT proceeds through three clearly defined treatment phases, provided in about 15 to 20 treatment sessions over a period of 9 months on average:

- **Phase 1. Parents restore weight.** This phase (sessions 1 through 10) deals almost exclusively with the reinforcement of parental efforts to support the adolescent in terms of weight restoration. The therapist carefully guides the parents through this process, always with great deference to their capacity to get this job done. At the same time, the clinician is relentless in his/her support for the predicament the adolescent finds him/herself in. The treating psychiatrist should manage comorbid psychiatric diagnoses.
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Note, there are no RCTs examining pharmacotherapy for adolescents with AN; however, there is clinical evidence that it is helpful to address these co-existing psychiatric disorders with appropriate psychotropic medications. For instance, there is promising although limited evidence to suggest the relative benefit of atypical antipsychotics to be helpful for this patient population. The team pediatrician monitors medical stability. Treatment begins to advance to Phase 2, once the adolescent approaches 90% of expected body weight, and the parents are seen to demonstrate confidence around their capacity to understand and manage the illness.

• **Phase 2. Parents return control over eating to the patient.** In Phase 2, which typically lasts 5 to 7 sessions, the clinician helps the parents to return control over eating to the adolescent. This process is conducted in a cautious and age-appropriate way, ie, managing food choice and quantities is not the same for a 17-year-old compared with a 12-year-old.

• **Phase 3. Review of adolescent development.** Finally, the clinician progresses to the third phase of treatment with the task of weight restoration largely completed. Discussions during this brief phase of treatment (2 to 4 sessions) centers on a review of the adolescent developmental process, which is no longer defined by the eating disorder.

While involvement of parents in the treatment of their adolescent offspring seems to be indicated by authoritative guidelines, and with FBT the most promising candidate, clinicians should still consider alternative therapies, such as adolescent-focused treatment (AFT). AFT has been shown to be a credible alternative treatment for adolescents when parents are unwilling or not able to participate in FBT, or when eating disorder symptoms are less severe. There is no doubt other treatments (eg, psychodynamic psychotherapy) are effective for some cases, although such treatments lack scientific support.

Treatment guidelines for adolescents with BN are somewhat less clear than is the case for AN. This may be, in part, because far fewer RCTs have been published for this patient population. Nonetheless, the available evidence suggest that a similar approach as the one described for adolescent AN, could be helpful for adolescents with BN. FBT for BN has also been manualized, providing the clinician with clear guidelines for intervention. At the same time, cognitive-behavioral therapy (CBT), well established in terms of its efficacy for adults with this diagnosis, has been shown to be equally promising for adolescents. Despite the prominent, albeit adjunctive, role SSRIs play in the treatment of BN in adults, only one open-label trial of fluoxetine has shown benefit for a small sample of adolescent patients with BN.

Taken together, treatment guidelines for adolescents with EDs are based on modest available data. As a result, it will be hasty to overstate the efficacy of FBT for this patient population. However, the absence of empirical data supporting alternative treatments does elevate FBT as the current preferred treatment of AN in medically stable adolescents. Some recent advances of note include, but are not limited to, more intensive FBT day programs; adaptive FBT that is more targeted on the needs of individual families; FBT that incorporates skills training from other well-established therapies; and current or proposed studies that evaluate other treatments such as enhanced cognitive behaviour therapy (CBT-E). Compared with adolescent AN, we still know little about effective treatments for adolescent BN. Moreover, few alternatives to either FBT or CBT have been advanced. Only the third, but also the largest, multi-site RCT for this patient population, is now nearing completion.

At this stage, clinical guidelines for adolescent EDs are few, but based on the current state of research and clinical evidence, clinical care should be directed in the following ways (also see References 8 and 9):

• Medically unstable adolescents with AN or BN should be admitted to an inpatient unit for stabilization (refeeding for AN and curtailling of binge eating and purging for BN)

• Medically stable adolescents with AN should be treated on an outpatient basis, with the parents taking the lead in the patients care

• Medically stable adolescents with BN should be treated as outpatients with a family-based approach or CBT proving to be the most promising treatments at this time

• A pediatrician/adolescent medicine physician should follow all adolescents with EDs, as is clinically appropriate

Treating eating disorders in adolescents continues to be a considerable challenge to families and clinicians alike. Many patients do not have the benefit of early diagnoses followed by prompt best-practice interventions. While we should lament the limited evidence available, we have made considerable advances over the past two decades in both the understanding and treatment of these disorders in the adolescent population. Perhaps not surprising, engaging families to capitalize on their care and dedication to their offspring so far has proved to be the most promising treatment.
Disclosures:
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