

**Eating Disorders**



# Evidence Based Intervention

Practitioner Expertise | Best Available Evidence | Lived Experience Expertise

**Fast facts**

- For Anorexia Nervosa, restoration of weight is the first treatment priority.
- Family therapy is an essential part of treatment for children and adolescents.
- A multidisciplinary approach is necessary, including medical, dietary, and psychological elements. Regular medical monitoring is required during intervention.
- Hospitalisation or residential programmes should be used only when specialised outpatient interventions have been unsuccessful or are unavailable. Although inpatient treatment may be required where there is acute physical or medical risk.
- Medication (including alternative medicines) should be reserved for treating comorbid conditions, or intractable cases.

**Interventions that work – at a glance**

*This table represents a compilation of information from several different sources (Fonagy et al. (2015), The Matrix (2015), Hay et al., (2014), Lock (2015) and Dunnachie (2007)) and is designed to provide an overview only. Directly consulting these sources will provide considerable additional information.*

|   | Gold                            | Silver   | Bronze  | Not recommended                       |
|---|---------------------------------|--|---|---------------------------------------|
| <b>Anorexia Nervosa</b>   | Manualised family-based therapy | Adolescent focussed therapy<br><br>Behavioural interventions / brief reward programmes   | Manualised CBT                                  | Medication alone for Anorexia Nervosa |
| <b>Bulimia Nervosa, overeating, and atypical eating disorders</b> |                                 | Manualised family-based therapy<br><br>Manualised CBT<br><br>Interpersonal psychotherapy | Selective Serotonin Reuptake Inhibitors (SSRIs) |                                       |

## The fine print

1. Family Based therapies such as the Maudsley Family-Based Treatment (FBT) are indicated as a first line treatment for children and adolescents (Hay et al., 2013). Family therapy can still be helpful if there is a high level of conflict within the family, and in situations where parents are seen separately to the client if the child/adolescent doesn't want to join (Fonagy et al., 2015). There is not enough evidence to say conclusively that one family therapy approach is better than others (Fisher et al., 2010), and more research is needed.
2. Such as "CBT-E", though several caveats ought to be considered. Steinhausen (1995) cautioned that much of the research literature relates to adults in individual treatment, and individual therapy for young people with Anorexia Nervosa is unlikely to be effective unless they are motivated, and have intact cognitions (this is unlikely in very young children, when there is comorbid depression, or where the young person is severely underweight and medically compromised).
3. Medication shouldn't be used as the primary treatment for Anorexia Nervosa (NICE, 2004), although medication can usefully treat co-morbid illnesses, or extreme over-exercising, or refractory presentations (Lock & La Via, 2015; Fonagy et al., 2015).
4. Evidence for the efficacy of SSRIs is limited due to the lack of randomised controlled trials (Fonagy et al., 2015). Almost all studies have been carried out with adults (Lock & La Via, 2015).
5. If individual therapy is the client's first choice, and there is not significant family disruption, it is best to treat Bulimia Nervosa first with a manualised CBT approach (NICE, 2004; Fonagy et al., 2015).
6. Behavioural interventions / brief reward programmes are the interventions of choice for short-term weight gain of 4-5kg, to reduce the punitive aspects of some interventions (The Matrix, 2015).
7. Adolescent focussed therapy targets self-efficacy and autonomy with reference to adolescent development. It is indicated for adolescent clients when FBT is not possible (Lock & La Via, 2015).
8. Interpersonal psychotherapy has a growing evidence-base in adults, and may be an alternative to CBT, but may take longer to achieve the same outcome (The Matrix, 2015).

## Description and demographics

The description of Anorexia Nervosa in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) involves low body weight resulting from a restriction of energy intake; behaviour that restricts weight gain or a fear of gaining weight; and a sense of self that is disproportionately influenced by weight and body shape (American Psychiatric Association, 2013). There are two subtypes of Anorexia, namely a restricting type, and a binge eating / purging type. Children and adolescents with Anorexia tend to present differently to adults. Specifically, they tend not to verbalise abstract thoughts, so emotional experiences may manifest as food refusal leading to malnutrition (Lock & La Via, 2015). Parental descriptions of children's behaviour are essential, as minimisation, denial and a lack of insight can make the child or adolescent's self-report unreliable (Lock & La Via, 2015).

Anorexia has one of the highest rates of mortality of all mental health difficulties – typically 5-7% in adult studies, although mortality has been as high as 18% in some samples (Lock & La Via, 2015). Mortality tends to result from medical complications associated with low body weight, or from suicide. Co-morbidity with other difficulties, particularly mood, anxiety and substance use disorders is common (Bailey et al., 2014). Reassuringly, the prognosis for adolescents is typically more encouraging than that of adults (Lock & La Via, 2015).

DSM-5 (American Psychiatric Association, 2013) describes Bulimia Nervosa as involving eating a large amount of food in a discrete period of time, and a feeling of the eating being out of control during that time. There is also recurring compensatory behaviour to prevent weight gain, often including fasting, exercise, diuretics, laxatives, or vomiting. Finally, the child or young person's evaluation of themselves is disproportionately influenced by weight and body shape. Binge Eating Disorder presents similarly, but without the compensatory behaviours described above.

Avoidant Restrictive Food Intake Disorder (ARFID) is a new diagnosis in DSM 5, and includes restricting or avoiding food without weight or body shape concerns, and without efforts to lose weight that are related to psychological developmental issues (American Psychiatric Association, 2013). Children and adolescents might present with very selective eating, a fear of trying new foods, or enhanced sensitivity to the texture, taste or appearance of food (Lock & La Via, 2015).

The lifetime prevalence rate for eating disorders (Anorexia and/or Bulimia) in a large New Zealand sample was 1.7% (Oakley Browne et al., 2006). Lifetime prevalence is the proportion of the New Zealand population who had experienced an eating disorder at any point in their life. The median age of onset in this study was 17 years (Oakley Browne et al, 2006).

There is very little research exploring the prevalence of eating disorders for Māori and Pacific populations in New Zealand. An older, but significant study, Te Rau Hinengaro: The New Zealand Mental Health Survey (Oakley Browne et al. 2006) found higher rates of mental health issues generally in Māori, compared with Pacific and other ethnicities. This finding was unchanged, even allowing for age, gender, and socioeconomic factors. More specifically, Māori and Pacifica were at higher risk than other ethnic groups for developing eating disorders (Oakley Browne et al., 2006). Importantly, strength of Māori ethnic identity (cultural connection) has been shown to be associated with lower levels of weight and body image concerns in female university students (Talwar et al., 2012). There are no known Māori-specific or culturally appropriate adaptations to mainstream interventions for eating disorders.

Finally, in relation to the evidence-base for interventions in this area it is important to consider the broader context. For example, when a child or young person is identified as having an eating disorder such as Anorexia Nervosa, the first (and usually urgent) priority is to address their medical needs through hospitalisation and/or refeeding. As such, few studies have explored allocating child and adolescent clients with moderate to severe presentations to a placebo or waiting-list comparison group. Also, the great majority of studies involve adult clients, with only a small number of studies focusing on child and adolescent groups. For these reasons, it has been difficult to establish an evidence-base for effective interventions using traditional research methodologies, and treatment recommendations have usually been based on clinical consensus (i.e. the opinion of a group of experienced experts) and 'poor quality' research trials without control groups (RANZCP, 2004). The evidence base for interventions is not well established, and there is a pressing need for more research (Bailey et al., 2014). The process of forming clinical guidelines despite the lack of research studies using formally accepted methods is necessary, but it is important to be aware of the limitations to these.

## References

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V). Arlington, VA: American Psychiatric Association.

Bailey, A. P., Parker, A. G., Colautti, L. A., Hart, L. M., Liu, P., & Hetrick, S. E. (2014). Mapping the evidence for the prevention and treatment of eating disorders in young people. *Journal of Eating Disorders* 2(5).

Dunnachie, B. (2007). Evidence-based Age-appropriate Interventions – A guide for child and adolescent mental health services (CAMHS). Auckland: The Werry Centre for Child and Adolescent Workforce Development.

Fisher, C. A., Hetrick, S.E., Rushford, N. (2010). Family therapy for anorexia nervosa. Cochrane Database of Systematic Reviews, Issue 4.

Fonagy, P., Cottrell, D., Phillips, J., Bevington, D., Glaser, D., & Allison, E. (2015). What Works for Whom? A critical review of treatments for children and adolescents (2<sup>nd</sup> Ed). New York: Guilford.

Hay, P. J., Chinn, D., Forbes, D., Madden, S., Newton, R., Sugenor, L., Touyz, S., & Ward, W. (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Australian and New Zealand Journal of Psychiatry 48(11), 1-62.

Hay, P. J., Claudino, A. M., Smith, C. A., Touyz, S., Lujic, S., Madden, S. (2013). Inpatient versus outpatient care, partial hospitalisation and wait-list for people with eating disorders. Cochrane Database of Systematic Reviews, Issue 12.

Lock, J. (2015). An update on evidence-based psychosocial treatments for eating disorders in children and adolescents. Journal of Clinical Child & Adolescent Psychology 44(5), 707-721.

Lock, J., La Via, M. C., & The American Academy of Child and Adolescent Psychiatry Committee on Quality Issues. (2015). Journal of the American Academy of Child and Adolescent Psychiatry 54 (5), 412-425.

National Institute for Health and Care Excellence (NICE; 2004). Eating Disorders in Over-8s: Management. Clinical Guideline.

Oakley Browne, M. A., Wells, J. E., Scott, K. M. (Eds.) (2006). Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Ministry of Health.

Royal Australian And New Zealand College Of Psychiatrists (RANZCP) Clinical Practice Guidelines Team For Anorexia Nervosa (2004). Australian and New Zealand Clinical Practice Guidelines for the Treatment of Anorexia Nervosa. Australian and New Zealand Journal of Psychiatry 38 (9), 659-670.

Steinhausen, H. C. (1995). Treatment and outcome of adolescent anorexia nervosa. Hormone Research 43, 168-170.

Talwar, R., Carter, J.D., & Gleaves, D.H. (2012). New Zealand female body image: What roles do ethnicity and body mass play? New Zealand Journal of Psychology, 41(1), 69-77.

The Matrix (2015). A Guide to Delivering Evidence-based Psychological Therapies in Scotland. Scotland: NES.