Commentary

Eating disorders treatment in child and adolescent psychiatry

Jacob Harris

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ABSTRACT

Recent research in child and adolescent psychiatry on the multimodal treatment of eating disorders has resulted in a large rise in randomised controlled trials and comprehensive reviews. This review seeks to highlight recent results on the medical and psychological management of anorexia nervosa, bulimia nervosa, and Avoidant/Restrictive Food Intake Disorder (ARFID).

Key Words: *Binge Eating Disorder, Cognitive-Behavioral Therapy*

INTRODUCTION

Eating disorders have one of the greatest Disability-Adjusted Life Years (DALYs) among all mental illnesses in adolescents and y-oung adulthood. Anorexia nervosa and bulimia nervosa were the 12th highest cause of DALYs in 15-19-year-old girls in high-income countries in the Global Burden of Disease Study 2013, accounting for 2.2% of all DALYs. However, these statistics do not reflect the entire economic and emotional impact on society and families, even if caregivers are still important in this age range. Anorexia nervosa and atypical anorexia nervosa are by far the most common eating disorders among patients admitted to Child and Adolescent Psychiatric (CAP) treatment or to paediatric units with a CAP liaison service, while bulimia nervosa and Avoidant/Restrictive Food Intake Disorder (ARFID) are seen less frequently. Individuals suffering from Binge Eating Disorder (BED) are typically encountered in obesity specialized clinics. As a result, this article will focus on the medical and psychosocial management of young people with threshold and subthreshold anorexia nervosa.

There has been a significant surge in big and methodologically sound investigations in recent years. Several significant Randomized Controlled Trials (RCTs) and systematic reviews have recently been published evaluating various treatment venues, refeeding procedures, and psychotherapy therapies for adolescent and juvenile anorexia nervosa. Individuals with anorexia nervosa aged 15-24 years have a greater death risk, with a standardized mortality rate of 11.5 by 1 year after discharge than those with other significant disorders in adolescence, such as asthma, type 1 diabetes, and any other mental problem. Nonetheless, disparities in national healthcare policies result in demographic inequalities in inpatient CAP or pediatric units. Specialized eating problem care is uncommon in most countries. Several specialized eating disorder national health services have recently been developed in the United Kingdom, resulting in a much shorter period before the patient gets contact with the expert s-ervice and the length of the eating problem before treatment. One of the main aims of the therapy of teenage anorexia nervosa is the restoration of a healthy body weight, which implies age-appropriate development and the resumption of menstruation. However, there is no agreement on what constitutes a healthy body weight and, as a result, what constitutes a target weight. According to recent research on teenage anorexia nervosa, an age-adapted BMI percentile of 25 is required for the return of menstruation; consequently, this number may be recommended as a reference weight for the majority of adolescent patients. There is now a debate regarding how to continue with refeeding critically malnourished people. According to a comprehensive analysis of children and adolescents and consistent with standard clinical practice, the first advised calorie intake ranges from 1000 to more than 1900 kcal. Many doctors are concerned about the so-called refeeding syndrome, which can result in serious cardiac, renal, and neurological problems. Recent observational research, which included a comprehensive analysis of 27 studies with adults and adolescents as well as a short RCT, found no difference in the occurrence of the refeeding syndrome in adolescents who began on a lower vs. higher calorie diet.

Psychotherapy is a crucial component of CAP treatment of anorexia nervosa, whether administered individually or through a family-oriented approach in inpatient, day patient, or outpatient settings. Because of the widespread acceptability of Cognitive-Behavioral Therapy (CBT) for nonrestrictive eating disorders, this treatment method has been adapted to treat all types of eating disorders, including anorexia nervosa, in outpatient and inpatient settings (CBT enhanced, CBT-E). CBT-E in teenagers comprises frequent sessions for caregivers and is based mostly on Fairburn's idea for adults. Data from two recent Italian trials of CBT-E show that it is beneficial for both inpatient and outpatient adolescent treatment. However, neither research included a control group.

Recent studies stress the significance of family engagement and 'caring for careers. Family members of anorexia nervosa patients,

Editorial office, Journal of Clinical Psychiatry and Neuroscience, United Kingdom

Correspondence: Harris J, Editorial Office, Journal of Clinical Psychiatry and Neuroscience, United Kingdom; E-mail: clinicalpsychiatry@neurologyjournals.org

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particularly those with a chronic course, face significant anguish and hardship and frequently suffer from mental problems themselves. Treasure and Schmidt's group in London created a skills training intervention programme for caregivers [Experienced Caregivers Helping Others (ECHO)] that included a book, DVDs, and five phone calls, as well as a pragmatic RCT. The study included 178 people who had previously been inpatients and were randomly assigned to either the active arm with the caregiver programme in addition to TAU or TAU only; 11 of the participants were teenagers. Patients in the ECHO group used the bed considerably less 7-12 months after discharge.

Large and methodologically sound systematic evaluations and RCTs of specialist therapy of teenage anorexia nervosa and, to a lesser extent, bulimia nervosa have made significant progress. We've learned how to improve weight restoration in malnourished adolescents and minimize refeeding issues, but we still don't know what the best goal weight is for long-term remission. FBT dominates psychotherapeutic research, which is largely undertaken by the same working group examining different forms of this therapy technique.

There is an urgent need for replication of the results as well as adequately powered trials to determine the superiority of FBT versus individual therapy, particularly in the long-term unpublished data. Regardless of the strategy, only around one-third to one-half of patients stay weight-restored in the long run, and these figures may be overstated due to significant drop-out rates during follow-up.

As a result, investigations on preventative strategies to permanently preserve remission and how to support individuals with primary treatment-resistant anorexia nervosa are urgently needed. We are only getting started with ARFID; evidence-based treatment recommendations must be created to help therapists, parents, and patients cope with this sometimes debilitating and unpleasant illness.