

Eating Disorders in Childhood and Adolescence

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The eating disorders – anorexia nervosa, bulimia nervosa and binge eating disorder – affect a small but significant percentage of young people with mental health disorders. Anorexia nervosa (AN) affects about 0.5% of female adolescents and bulimia nervosa (BN) affects about 1–2%. Although numbers are small, it is the case that anorexia nervosa has the highest morbidity and mortality of any of the psychiatric disorders, claiming the lives of approximately 20% of sufferers within 10 years.

Additionally, evidence now supports a trajectory from adolescent AN, through BN to finally arrive at an adult binge eating disorder. The health consequences are large, with sufferers often also dealing with co-morbid depression, social withdrawal and physical health issues. Research shows that women with a history of adolescent eating disorder have significant impairments in health, self-image and social functioning, even after a full recovery.

Given these deleterious effects, it is important that individuals with these problems receive timely assessment and intervention.

Presentation pitfalls

Children and adolescents with eating disorders are unlikely to present themselves for treatment, or to see their eating as a primary problem. Typically, they report emotional or physical symptoms instead. They will discuss feeling moody, tired, cold dizzy and faint, or having poor concentration, and are likely to see these symptoms as issues. For young people, issues of weight and shape may not be as clearly delineated from other broader issues of adolescence, as they will be for older sufferers.

Although young people with eating disorders tend to have the same symptoms and preoccupations as older sufferers, they may not easily discuss their concerns regarding shape and weight. They are more likely to discuss concerns about being “a good person” rather than wanting to be thin.

Appearances can be deceptive. Children do not always appear underweight on presentation. However, when growth trajectories are measured, these children may have ceased to grow or develop as would otherwise be expected.

Assessment is broad

A careful assessment ensures that the young person obtains timely and effective treatment. Due to potentially irreversible effects on physical growth and development, the threshold for medical intervention ought to be lower for adolescents than adults. Adolescents may develop permanent growth retardation if the disorder occurs before fusion of the epiphyses, along with impaired bone calcification and mass during the second decade of life, thus increasing the risk of osteoporosis and fracture later in life.

Medical complications can occur in young sufferers before evidence of significant weight loss. In AN, it is important to assess heart rate, orthostatic vital signs, and serum electrolytes, phosphorus, glucose, magnesium and potassium. Lethal medical complications in BN are rare, but trauma to the gastro-intestinal tract, fluid and electrolyte imbalance and renal dysfunction can occur. Additionally, it is important to assess the degree of laxative abuse (if any), and growth retardation.

Assessment not only includes the possible physical consequences of malnutrition and starvation, but also education for the youngster and their family about the broad effects of maintaining a low weight in regards to their physical well-being, cognitive abilities, mood and social development. Often children and adolescents will be unaware that their unpleasant symptoms are attributable to limited eating.

Treatment

Treatment for children and adolescents with eating disorders is generally multidisciplinary in nature, and involves ongoing medical, psychological and nutritional input. Research demonstrates that similar treatments are effective for adults and adolescents with BN.

The most widely supported treatment for eating disorders is cognitive behaviour therapy – widely validated in BN but with limited current evidence supporting its efficacy with AN. There is some evidence supporting the use of the Maudsley Family Therapy model with adolescents suffering from AN.

In general, psychological treatment for eating disorders involves not only addressing the characteristic eating psychopathology, but also mastery of the developmental tasks and the psychosocial issues central to this age group.

Treatment initially focuses on developing patterns of regular eating, and preparing the individual for weight gain (if indicated), addressing issues regarding weight and shape, perfectionism, mood intolerance and interpersonal difficulties (as indicated by an individual formulation), and maintenance. Involvement of family members is indicated, in order to remove any perceptions of blame or guilt that may exist within the family.

Outcomes and prognosis

Many factors affect the prognosis of individuals with eating disorders. Often noted is that early age of onset and treatment predict good outcomes, suggesting that it is more beneficial for adolescents to be referred for treatment as early as possible.

Key points

Children and adolescents:

- ◆ May present describing emotional and physical problems, rather than difficulties with eating and food
- ◆ Do not always appear underweight
- ◆ May suffer permanent growth retardation if not treated early
- ◆ May be unaware their unpleasant symptoms are related to eating.
- ◆ Require multidisciplinary treatment.