

Incorporating Social Support in the Treatment of Anorexia Nervosa: Special Considerations for Older Adolescents and Young Adults

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Currently, research support is strongest for family-based treatment (FBT) for the treatment of anorexia nervosa (AN) in adolescents. However, a strong evidence base for treatments for older adolescents and young adults with AN is lacking. Emphasizing social support in the treatment of AN may be beneficial for older adolescents and young adults with AN. This paper provides a brief review of the literature on FBT for adolescent AN and provides a case example of adolescent AN treated with FBT. We then discuss novel treatments that have incorporated social support for older adolescents and young adults with AN, such as modified FBT and couple-based interventions. We provide case studies of each of these novel treatment approaches as well. Additionally, this paper highlights and discusses developmental considerations and challenges in working with older adolescents and young adults with AN.

Anorexia nervosa (AN) is a serious psychiatric illness characterized by engagement in behaviors (e.g., food restriction, purging, excessive exercise) that lead to severe weight loss or failure to gain appropriate weight, along with body image disturbance, overvaluation of shape and weight, and intense fear of becoming fat (American Psychiatric Association, 2013). According to the DSM-5, AN is characterized by two subtypes: individuals who engage in binge eating and/or purging (AN binge eating and purging subtype) and those who do not regularly binge eat and/or purge (AN restricting subtype; American Psychiatric Association, 2013). Onset of AN most commonly occurs in adolescents between ages 13 and 18 (Weaver & Liebman, 2011). The lifetime prevalence of AN is between 0.5 and 2% (Sigel, 2008; Smink, van Hoeken, & Hoek, 2013). In addition to significant psychosocial impairment (Birmingham & Treasure, 2010; Tiller et al., 1997) and high rates of co-occurring psychiatric diagnoses, including anxiety, mood, substance use, and personality disorders (Herpertz-Dahlmann, 2009; Herzog, Nussbaum, & Marmor, 1996; Herzog et al., 1992), AN is associated with the highest mortality of all mental disorders (Chesney, Goodwin, &

Fazel, 2014; Harris & Barraclough, 1998). Death in this population commonly results from suicide or from the consequences of starvation (Arcelus, Mitchell, Wales, & Nielsen, 2011; Franko et al., 2013; Keshaviah et al., 2014; Papadopoulos, Ekblom, Brandt, & Ekselius, 2009; Preti, Rocchi, Sisti, Camboni, & Miotto, 2011). The myriad of medical sequelae associated with AN are alarming and include fluid and electrolyte imbalances (e.g., hypokalemia), bone loss (e.g., osteopenia, osteoporosis), cardiovascular complications (e.g., bradycardia, orthostatic hypotension), gastrointestinal problems (e.g., delayed gastric emptying), and endocrine problems (e.g., growth retardation; Golden et al., 2003).

AN often follows a prolonged course and is associated with high morbidity. Remission rates from AN have been found to vary widely (from 29 to 84%) depending on length of follow-up and type of study (Keel & Brown, 2010). Additionally, approximately a third of patients with AN transition to another type of eating disorder, such as bulimia nervosa or other specified or unspecified eating disorders (previously eating disorder not otherwise specified; Keel & Brown, 2010; Milos, Spindler, Schnyder, & Fairburn, 2005).

The exact etiology of AN is unclear, although most researchers and clinicians agree that genetic and biological predispositions interact with environmental and sociocultural influences and individual psychological traits (Klump, Bulik, Kaye, Treasure, & Tyson, 2009; Treasure, Claudino, & Zucker, 2010). AN runs in families (Lilenfeld et al., 1998; Strober, Freeman, Lampert, Diamond, & Kaye, 2000) and twin studies have resulted

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in heritability estimates between 28 and 74% (Trace, Baker, Penas-Lledo, & Bulik, 2013). While there may be familial risk factors and genetic vulnerabilities that predispose individuals to the development of AN, empirical literature does not support the premise that families directly cause AN (Le Grange, Lock, Loeb, & Nicholls, 2010). Personality traits such as negative emotionality, perfectionism, and negative urgency are risk factors for eating disorders (Culbert, Racine, & Klump, 2015). The primary sociocultural influence that has been studied as a risk factor for eating disorders is the thin beauty ideal, which encourages extreme dieting and weight control practices (Culbert et al., 2015; Stice, 2002). Additionally, teasing and bullying focused on food, weight, and shape issues is also associated with an increased risk of developing disordered eating (Quick, McWilliams, & Byrd-Bredbenner, 2013).

Given the significant morbidity and mortality associated with AN, treatment is critical. Treatment of AN typically first focuses on weight regain and medical stabilization. In order to achieve these goals, individuals must go through a refeeding process and decrease eating disorder behaviors, such as restricting, purging, and excessive exercise. Additional goals later in treatment include decreasing overemphasis on weight and shape and improving quality of life. Because of the ego syntonic nature of AN, whereby patients experience AN as being consistent with their identity, patients with AN often express ambivalence about treatment and low motivation to change (Vitousek, Daly, & Heiser, 1991). Engaging in weight control behaviors is reinforced through decreases in negative affect (Engel et al., 2013) and many individuals with AN experience the refeeding process as uncomfortable and aversive. As a result of these challenges in the context of treatment, a large number of patients drop out of treatment prematurely. Therefore, much remains unknown about effectively treating AN.

While approaches such as medication, inpatient hospitalization, and residential treatment are used clinically, empirical support is lacking for these modalities (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007). Outpatient individual and family therapies have received more support in the literature. A review of randomized clinical trials (RCTs) for AN suggests that, for adults, cognitive-behavioral therapy (CBT) may be more likely than other treatments to produce weight gain and reduce relapse rates (Bulik et al., 2007). For adolescents with AN, the research support is strongest for family-based treatment (FBT; Lock, 2011), although one recent study comparing FBT with individual therapy found differences only at follow-up and not at the end of treatment (Lock et al., 2010). Overall, evidence to date does not support one specific treatment for both adolescent and adult AN. Modifications to existing treatments and the development of new treatments

continue to be investigated in the field with the aim of finding more efficacious approaches to treating AN.

Recently, there has been an emphasis on the role of caregivers and social support systems in the treatment of AN. Individuals with AN are more likely to have poor interpersonal relationships, be more socially isolated (Arkell & Robinson, 2008), and lack social support (Tiller et al., 1997). Parents and partners of individuals with AN have been shown to experience significant distress and report that AN results in negative consequences for both the patient and the family (Whitney, Haigh, Weinman, & Treasure, 2007). Several studies have been aimed at providing education and reducing distress and expressed emotion in caregivers of patients with AN (Goddard et al., 2011; Grover et al., 2011; Macdonald, Murray, Goddard, & Treasure, 2011; Sepulveda, Whitney, Hankins, & Treasure, 2008). Given the empirical evidence for FBT for adolescents with AN, as well as the research on the impact of AN on the individual's social support networks, emphasizing social support in the treatment for AN for both older adolescents and young adults may help optimize treatment outcomes. Additionally, given the high levels of distress experienced by parents and partners, engaging them in treatment may help reduce treatment dropout, as parents and partners may be highly motivated to receive support and encourage the patient to continue in treatment.

Family Therapy for Adolescent AN

Family therapy has been one of the most common treatments for adolescents with AN since the 1970s (Minuchin et al., 1975; Palazzoli, 1974). Initially, family therapy was recommended for the treatment of AN based on the premise that there were "interactional difficulties" between the patient and the family (Minuchin, Rosman, & Baker, 1978; Palazzoli, 1974). More recent conceptualizations of AN, however, indicate that families are not the cause (Le Grange et al., 2010; Lock, 2010). While some family characteristics may influence compliance with and response to family therapy, such as high levels of expressed emotion (Le Grange, Eisler, Dare, & Russell, 1992) or the family is nonintact (Lock, Agras, Bryson, & Kraemer, 2005), engaging and empowering families can be beneficial for treatment outcome (Le Grange, 1999). Family therapy is considered the treatment of choice for children and adolescents with AN based on clinical trials and outcome data (NICE, 2004).

Several different types of family therapy for adolescent AN have been studied. The first controlled efficacy trial was completed by a group of researchers at the Maudsley Hospital, which compared family therapy (later manualized into FBT; Lock, Le Grange, Agras, & Dare, 2001) and individual supportive therapy (Russell, Szmukler, Dare, & Eisler, 1987). Ninety percent of adolescents in the family

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