CBT WITH CHILDREN, ADOLESCENTS AND FAMILIES

Eating Disorders

Cognitive Behaviour Therapy with Children and Young People

Simon G. Gowers
and Lynne Green

"These authoritative, yet practical books will be of interest to all professionals who work in the field of child and adolescent mental health" - Alan Carr

Eating Disorders

Eating disorders comprise a range of physical, psychological and behavioural features that often have an impact on social functioning and can invade most areas of the sufferer's life. Although eating and weight disorders are common in children and adolescents, there is a scarcity of practical guidance on treatment methods for eating disorders in young people.

In this book, Simon Gowers and Lynne Green bring together up-to-date research, clinical examples and useful tips to guide practitioners in working with young people, as well as helping families of children and adolescents to deal with their difficulties. *Eating Disorders* provides the clinician with an introduction about how CBT can be used to challenge beliefs about control, restraint, weight and shape, allowing young people to manage their eating disorder. Chapters cover:

- preparing for therapy
- a CBT treatment programme
- applications and challenges.

This practical text will be essential reading for mental health professionals, paediatric teams and those in primary care working with children and adolescents with eating disorders. It will benefit those working with both sufferers themselves and families who have difficulty understanding the disorder.

Online resources:
The appendices of this book provide worksheets that can be downloaded free of charge to purchasers of the print version. Please visit the website www.routledgementalhealth.com/cbt-with-children to find out more about this facility.

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CBT with Children, Adolescents and Families
Series editor: Paul Stallard

'The *CBT with Children, Adolescents and Families* series, edited by Professor Paul Stallard and written by a team of international experts, meets the growing need for evidence-based treatment manuals to address prevalent psychological problems in young people. These authoritative, yet practical books will be of interest to all professionals who work in the field of child and adolescent mental health.' – *Alan Carr, Professor of Clinical Psychology, University College Dublin, Ireland*

Cognitive behaviour therapy (CBT) is now the predominant treatment approach in both the NHS and private practice and is increasingly used by a range of mental health professionals.

The *CBT with Children, Adolescents and Families* series provides comprehensive, practical guidance for using CBT when dealing with a variety of common child and adolescent problems, as well as related family issues. The demand for therapy and counselling for children and adolescents is rapidly expanding, and early intervention in family and school settings is increasingly seen as effective and essential. In this series leading authorities in their respective fields provide detailed advice on methods of achieving this.

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Eating Disorders

Cognitive Behaviour Therapy with Children and Young People

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Part I

Introduction

1

Eating disorders and their management

Introduction

Eating disorders are fascinating mental health problems in a number of respects. In the current climate of increasing concern about the growth in rates of obesity, they highlight the ambivalent attitudes to eating and weight which are shared by many people and the problems which can arise from them. However, although weight and shape concerns are extremely common, particularly in young females, full-syndrome eating disorders are quite unusual in children and adolescents, and rates of referral to secondary care services are rarer still. Despite this, anorexia nervosa (AN) has the highest mortality rate of any psychiatric disorder, and in the UK, it is currently the most prevalent disorder within inpatient child and adolescent mental health services (O'Herlihy *et al.*, 2003). In many respects, it is the paradoxical nature of eating disorders which makes them so interesting; this includes the typical love–hate relationship with food, young persons' investment in their disorder in the face of the physical and social disability it brings, and, consequently and crucially with respect to this book, young peoples' characteristically ambivalent attitudes to treatment.

Eating disorders are by no means new phenomena; medical reports of AN date back to the seventeenth century, and the Victorian physicians Gull and Lasegue both assembled enough patients to constitute sizeable case series. However, despite this lengthy history, the aetiology of eating disorders is complex and ill-understood, and, with the exception of adult bulimia nervosa (BN) (which was not described until the 1970s), there has been limited research into the development of effective treatments.

Classification

Concerns about children's eating and weight are extremely common. In young children, parents and other carers take responsibility for a child's eating, and feeding is seen as one of the core tasks of parenting. In the course of development (in keeping with other behaviours), children's own choices play a growing part, and control of eating gradually transfers to the young person. Responsibility for eating (and therefore to some extent for weight) is negotiated (though generally covertly) with parents in a similar way to other aspects of growing independence. The psychiatric classification systems (ICD-10 and DSM-IV) reflect this developmental shift in distinguishing between 'feeding disorders of childhood' and 'eating disorders', which generally develop in adolescence or young adulthood.

Feeding disorders arise in the first 6 years of life and involve food refusal or extreme selective eating in the presence of adequate food and the absence of organic disease. They are extremely common – faddy eating occurs in over 20 per cent of pre-school children; rumination and regurgitation of food more rarely. In contrast to adolescent eating disorders, there is usually an absence of concern with fatness or other psychological or behavioural abnormality, though difficulties can often be identified in the relationship between the child and the mother.

Feeding disorders involve food refusal or selective eating

Eating disorders, however, comprise AN, bulimia nervosa (BN) and their variants. They typically develop in adolescence or early adulthood but sometimes arise in late childhood. The disorders share much the same psychopathology, and many patients migrate between the diagnoses or fulfil only partial syndromes. The ICD and DSM schemes for classifying and diagnosing eating disorders recognise the two main conditions, and their diagnostic criteria are similar. DSM-IV also lists a number of 'eating disorders not otherwise specified' (eating disorder NOS), including partial syndromes which are relatively common.

In practice, despite the above distinction there is some overlap between *feeding disorders* and *early-onset eating disorders*, i.e. those occurring in 8–12-year-olds. Eating disorders in this age group tend to be atypical and to confuse things further; such children often have a prior history of feeding difficulties. The terms 'selective eating', 'pervasive refusal' and 'food-avoidance emotional disorder' describe some of the atypical eating disorders of this age group.

The main eating disorders are anorexia nervosa and bulimia nervosa

Anorexia nervosa (AN)

Four features need to be present to make a diagnosis of AN:

- Overevaluation of the importance of weight and shape; that is, judging self-worth largely, or even exclusively, in these terms. This is often expressed as an intense fear of becoming fat and sometimes referred to as a distortion of body image.
- The maintenance of an unduly low body weight (that is less than 85 per cent of that expected, or a body mass index (BMI) below the 2nd percentile for age).
- Active control of weight by dietary restriction, exercise, vomiting or purgation.
- A widespread endocrine disturbance involving the hypothalamic-pituitary-gonadal axis. This is manifest as amenorrhoea in post-pubertal females, pubertal delay in pubescent females and as impotence and lack of sexual interest in males.

Applying the strict diagnostic criteria for AN to the clinical problems seen in children and adolescents poses certain problems. For example, some common clinical presentations do not fit the adult-oriented diagnostic criteria. In this age group, a significant number of those who are underweight due to purposeful dietary restriction show little evidence of overconcern about shape or weight: rather, their dietary restriction appears to stem from the perceived importance of controlling eating per se. Strictly speaking, such patients should not be given the diagnosis of AN since a central diagnostic feature is not present. Of course, it can be problematic to identify this psychopathology in younger patients owing to the difficulty children have describing their thoughts, attitudes and behaviour, combined sometimes with a reluctance to do so. Obtaining supplementary information from parents and other informants is important and can be illuminating. The psychopathology of AN should, however, not be inferred without good evidence, and other diagnoses may have to be considered.

Another problem centres on the weight criterion of AN, since it is difficult to use with children and younger adolescents. There are two main reasons for this: first, adult body mass index (BMI) norms do not apply to younger age groups; second, growth may have been stunted, with a resulting risk of underestimating the degree to which a particular child is underweight. To address these problems, it is advisable to compare the patient's current percentile for age, gender, weight and height with earlier ones if possible.

The amenorrhoea criterion also poses problems in pre-menarcheal cases. Given the range of normal development, it can be difficult to estimate which girls might otherwise be expected to have completed their puberty if they had not engaged in disturbed eating and weight control.

The key diagnostic features of anorexia nervosa are a distorted body image, extremely low body weight, significant dieting, exercise or purging, and endocrine disturbance

Bulimia nervosa (BN)

Three features are required to make a diagnosis of BN:

- overevaluation of the importance of shape and weight, as in AN
- the presence of recurrent binge eating, a 'binge' being an episode of eating during which an objectively large amount of food is eaten and there is a sense of loss of control
- the presence of extreme weight-controlling behaviour, such as strict dietary restriction, recurrent self-induced vomiting or marked laxative misuse.

The diagnosis of AN takes precedence over BN, and so the latter is a syndrome of normal weight.

It has recently been proposed that an additional eating disorder be recognised, namely 'binge eating disorder'. This is rather different in character from the other eating disorders and mainly affects middle-aged adults, so it is not particularly relevant to this book. A few overweight or obese adolescents will, however, regularly binge, with no compensatory weight-controlling behaviour, and thus fulfil this diagnosis.

The key diagnostic features of bulimia nervosa are a distorted body image, binge eating, significant dieting, and vomiting or laxative misuse

Clinical features

The eating disorders are syndromes comprising a range of physical, psychological and behavioural features. They usually have an impact on social functioning and eventually their effects pervade most areas of the young person's life.

AN and BN, and most cases of eating disorder NOS, share a distinctive 'core psychopathology' that is essentially the same in females and males, adults and adolescents. Whereas most people judge themselves on the basis of their perceived performance in a variety of domains of life (such as the quality of their relationships with their family and friends, their work, their sporting achievements, etc.), those with AN or BN judge their self-worth

largely, or even exclusively, in terms of their shape and weight and their ability to control them. This overevaluation of shape and weight results in a pursuit of weight loss and an intense fear of weight gain and fatness. It is important to note that it is weight loss that is sought, rather than a specific weight, so the subject never achieves a weight at which she can be content and relax her stance. Most of the other features of these disorders are secondary to this cognitive abnormality and its consequences (for example, dietary restriction and being severely underweight), and in Chapter 2 we will highlight the complex relationship between cognition, behaviour and physical features. In any case, in AN, there is a sustained and determined pursuit of weight loss and, to the extent that this pursuit is successful, this behaviour is seen as necessary rather than problematic. Indeed, successful dieting tends to be viewed as an accomplishment; as a consequence, young people with AN generally have a limited desire to change. In BN, equivalent attempts to restrict food intake are interspersed with repeated episodes of binge eating with the result that patients may see themselves as 'failed anorexics'. The great majority of these young people are distressed by their loss of control over eating, and this makes them easier to engage in treatment once they have presented to services, although because of associated shame and secrecy, they rarely do so on their own account before they reach adulthood.

The core features of AN and BN may be demonstrated in other ways. Many young people mislabel adverse physical and emotional states as 'feeling fat' and equate these with actually being fat. In addition, many repeatedly scrutinise aspects of their shape, focusing on parts that they dislike. This preoccupation may contribute to them overestimating their size. Others actively avoid seeing their bodies, assuming that they look fat and unattractive. Equivalent behaviour is seen with respect to weighing (weight checking), most patients weighing themselves frequently and as a result becoming preoccupied with trivial day-to-day fluctuations, whereas others actively avoid knowing their weight while nevertheless being highly concerned about it.

In AN, the pursuit of weight loss is successful, and a very low weight may be attained through severe and selective restriction of food intake, foods viewed as fattening being excluded. Anorexia (loss of appetite) is not usually a feature; rather, dietary control results in hunger, reinforcing fears of loss of control. Dietary restriction may also be an expression of other motives, including asceticism, perfectionism and competitiveness. Some young people engage in a driven type of exercising that also contributes to their weight loss. Self-induced vomiting and other forms of weight-control behaviour (such as the misuse of laxatives or diuretics) are practised by a subgroup who are more vulnerable to developing BN at a later date. Some have episodes of loss of control over eating, although the amount eaten is often not objectively large (subjective binge eating). Depressive and anxiety features, irritability, lability of mood, impaired concentration, loss of sexual interest and obsessional symptoms are frequently present. Typically, these features get worse as weight is lost and improve to a large extent with weight restoration. Interest in the outside world also declines as patients become

underweight, with the result that most become socially withdrawn and isolated. This, too, tends to reverse with weight gain and provides a degree of reinforcing momentum to treatment. As body weight is maintained at least 15 per cent below that expected, pubertal development is stunted or reversed. This results in either a delay in the menarche or secondary amenorrhoea in those who have completed puberty.

The aim of young people with BN is generally to adopt the eating behaviours seen in AN. But unlike the very disciplined restricting anorexics, their attempts to restrict food intake are punctuated by repeated episodes of binge eating. The amount consumed in these binges varies but is typically between 1000 and 2000 kcals per episode, and their frequency ranges from once or twice a week (the diagnostic threshold) to many times a day. In most cases, each binge is followed by compensatory self-induced vomiting or laxative misuse, but a small subgroup do not 'purge', but control their weight with exercise or longer periods of abstinence. The weight of most of these young people is in the healthy range (giving a body mass index (BMI) between the 25th and 75th percentiles), as the undereating and overeating cancel each other out. As a result, patients with BN do not experience the secondary psychosocial and physical effects of maintaining a very low weight, though the disorder has its own adverse consequences. Depressive and anxiety symptoms are prominent in BN – and a number of patients engage in substance misuse and self-harm (particularly cutting).

Although both syndromes comprise a range of physical features, maladaptive eating behaviours and abnormal cognitions, in AN, it is the emaciation that is generally the most striking. A range of endocrine abnormalities result from calorie restriction and weight loss and affect most hormonal systems, though cessation of sex hormone production is usually the most evident in girls, as it results in amenorrhoea. Gastrointestinal features often follow the maladaptive eating behaviours. Dieting can reduce gastric capacity while bingeing, purging and vomiting (more common in BN) can have a negative impact on the whole gastrointestinal system from mouth and teeth onwards.

Origins of weight and shape concern

The aetiology of eating disorders is thought to be multi-determined, and the same is probably true of the belief in the importance of weight and shape that underlies these disorders. A genetic component probably plays a part in the aetiology of both eating disorders. However, this may exert its effect in a number of ways from predisposing to physical vulnerability factors (a propensity to obesity or early puberty) or to certain personality traits that also act as vulnerability factors, such as perfectionism or impulsivity. It has been proposed that a range of family, physical and personality variables might then lead to an overvaluing of the importance of weight or restraint, both of which can result in dieting behaviour. Dieting is generally an early feature of

both AN and BN, both of which conditions can be seen as lying on a continuum of preoccupation with control (see Figure 1.1).

In classical restricting AN, the desire to exert control over eating and weight is often reflected in other aspects of the developing personality, the young person presenting as controlled, often obsessional and inflexible. The stereotypic young person with BN, however, shows alternating spells of impulsive loss of control with attempts at regaining it, often on a daily basis. This is sometimes also reflected in a more chaotic lifestyle, in which drug and alcohol use may be features.

It is the relationship between cognition, behaviour and physical features that has led to the cognitive-behavioural aetiological model, which will be reviewed in Chapter 2. This in turn provides the rationale for a cognitive behaviour therapy (CBT) approach. However, somewhat surprisingly, CBT has not yet been fully tested in clinical trials of adolescent eating disorders. We will therefore briefly review the range of other treatment approaches which have been proposed and the research evidence for their effectiveness.

Treatment approaches

The evidence for the effectiveness of treatments for child and adolescent eating disorders has been recently reviewed by the National Institute for Health and Clinical Excellence (NICE) in the UK, subsequently summarised by Gowers and Bryant-Waugh (2004). The NICE guideline made treatment recommendations classified from A (the strongest) to C (the weakest), depending on the strength of evidence. In considering the full range of psychological therapies, physical (including pharmacological) treat-

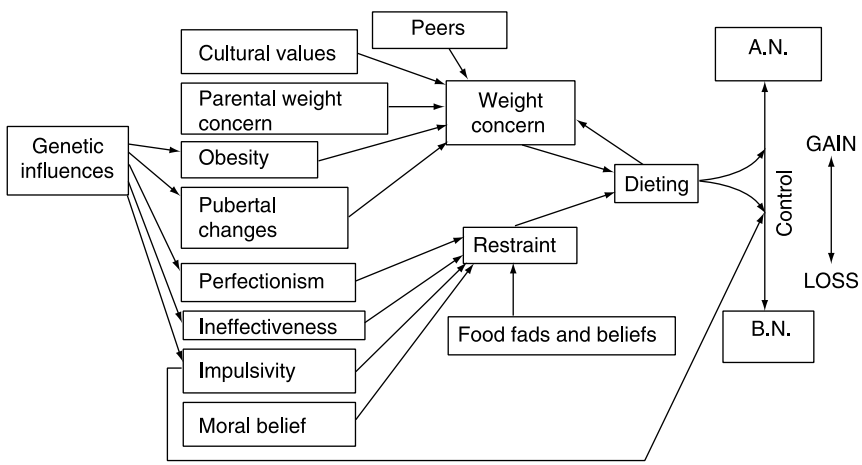

Figure 1.1 Origins of weight and shape concern (Gowers and Shore, 2001). Reproduced with permission from the Royal College of Psychiatrists. AN: anorexia nervosa; BN: bulimia nervosa

ment and service settings, the authors of the guideline were unable to make a single grade A treatment recommendation for AN across the age range, and the literature review revealed no randomised, controlled trials (RCTs) for BN in children and adolescents.

Guidelines on the management of child and adolescent eating disorders are therefore based mainly on expert clinical opinion and cohort studies rather than research trials. A number of academic bodies have published consensus guidelines, some specifically in relation to the management of children and adolescents. There is much greater emphasis in these on the management of AN than of BN, and on physical rather than other aspects of management.

There is little robust empirical evidence to recommend any one treatment approach

Physical management

In AN, the guidelines refer to the potentially irreversible effects on physical growth and development, and argue that the threshold for medical intervention in adolescents should be lower than in adults. Of particular importance, is the potential for permanent growth retardation if the disorder occurs before fusion of the epiphyses, and impaired bone calcification and mass during the second decade of life, predisposing to osteoporosis and increased fracture risk later. These features emphasise the importance of immediate medical management and ongoing monitoring by physicians who understand normal adolescent growth and development.

Medical complications can occur in younger subjects before evidence of significant weight loss. In treating a malnourished young person, we should take care to avoid the refeeding syndrome, by regular monitoring. This is more common with parenteral than enteral feeding, and fewer problems arise in hospital when young people are eating normal food.

The Royal College of Psychiatrists recommends an energy intake in excess of 3000 kcal/day for weight gain, while the American Psychiatric Association (APA, 2000) suggests 70–100 kcal/kg body weight/day during weight gain and 40–60 kcal/kg per day during a weight-maintenance phase.

There is little in the NICE guidelines to direct the physical management of BN, though a key objective in planning dietary programmes is to break the vicious cycle of dieting and binge eating. Lethal medical complications are rare in BN, but trauma to the gastrointestinal tract, fluid and electrolyte imbalance, and renal dysfunction can occur. As in AN, attention to the adverse dental effects of vomiting and specific preventative guidance on oral hygiene is recommended.