CBT-E for Age-Transition Eating Disorders

Subjects: Psychology, Clinical

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Many people with eating disorders transit from child and adolescent to adult clinical services. This transition often creates a gap in regular treatment and interruption of the therapeutic relationship with negative consequences. The change in the nature of the treatment often disorients patients and their parents. All-age eating disorder clinical services is a potential solution to address these challenges and enhanced cognitive behaviour therapy (CBT-E) is one of the major candidates among the individual psychological treatments to be the treatment of choice in all-age eating disorder services.

Keywords: Anorexia nervosa ; Bulimia nervosa ; Eating disorders ; Adolescents ; Age transition ; Treatment ; Cognitive behaviour therapy

1. Introduction

Almost 50 percent of eating disorders begin before age 18, and the mean age of onset of anorexia nervosa and bulimia nervosa is 17 and 18 years, respectively [1]. Eating disorders often persist for several years, and young people with these disorders require specialized outpatient and sometimes intensive therapies, such as residential or inpatient treatments, until they reach their mid-twenties and beyond.

The above data indicate that many people with eating disorders address the transition from child and adolescent to adult clinical services. This has been confirmed by studies showing that about 25-35 percent of teenage patients continue their treatment in adult eating disorder clinical services [2].

2. Problems Associated with the Transition from Adolescent to Adult Services

The transition from adolescent to adult eating disorders clinical services is associated with several challenges, which are more common in countries with an obligatory change of service at the age of 18 [3].

The transition can create a discontinuity in the care process by interrupting important and often positive therapeutic relationships with the child-adolescent team, creating a potentially harmful upheaval at a crucial time in the individual's treatment and potentially precipitating the deterioration of their illness. Patients and families often feel lost and abandoned during this transition.

The transition is also often abrupt and often occurs abruptly and may be associated with a gap in regular treatment because of organizational difficulties. Consequently, the young person may not receive treatment for a prolonged time in a crucial moment of their life.

Another common problem common is that the nature of the treatments offered to adolescents and adults is often markedly different, despite substantial evidence that they share the same eating disorder psychopathology (e.g., preoccupation with shape and weight, fear of weight gain, low weight, strict dieting, excessive exercising, binge eating, and purging behaviours, body checking and avoidance) [4]. Indeed, Adolescent services usually deliver family-based treatments (FBTs), whereas adult services mainly offer individual psychological therapies. The two approaches significantly diverge in the conceptualization of eating disorders, and both the patients' roles and the nature and extent of parental involvement differ widely [5].

FBT separates the illness from the patient (externalization), with the eating problem or symptoms being seen as belonging to the entire family. Parents are empowered to take control of their adolescent's eating temporarily, relegating the young patient to a passive role. In these treatments, the adolescent is not actively involved, while the involvement of the parents is vitally important. FBT is not generally delivered in adult eating disorder services, mainly because parents have too much difficulty taking eating control of their adult child's eating.

Evidence-based individual psychological treatments, such as enhanced cognitive behaviour therapy (CBT-E), do not usually separate the illness from the patient, as the problem is seen as belonging to the individual. Therefore, the patient is actively involved in addressing their illness, while the involvement of parents or significant others is helpful but not essential.

With these differences in mind, it is understandable why the transition from FBT to individual psychological treatment, creating a discontinuity in the nature of care, may often disorient patients and their parents about the procedures and strategies that need to be adopted to overcome their illness, increasing the risk of relapse and negative treatment outcome [6].

Table 1 shows the principal differences between FBT and CBT-E

Table 1. Principal differences between family-based treatment (FBT) and enhanced cognitive behavior therapy (CBT-E).

	FBT	**CBT-E**
Conceptualization of the eating disorders	The problem belongs to the entire family The illness is separated from the patient	The problem belongs to the individual It does not separate the illness from the patient
Adolescent's role	Not actively involved	Actively involved
Parent's role	Vitally important	Useful but not essential

3. A Potential Solution: All-Age Eating Disorder Clinical Services

A potential solution to the above challenge, and implemented in some countries, is organizing clinical services that cover the age range from childhood to young adulthood. These services have the advantage of avoiding disruption of the treatment and discontinuity in the care process. It is also possible to implement evidence-based psychological therapies that can be expanded to the transitional age youth. For this purpose, there are two main possible strategies: article continues after advertisement [6]:

1. *A reach-up model*, extending, for example, the family treatments in the transitional age.
2. *A reach-down model*, adapting, for example, individual psychological treatments to the transitional age.

The second strategy seems preferable because patients in the transitional age (e.g., 17-19 years) may find an adapted "adult" form of treatment more acceptable than a family-style form.

4. Is CBT-E a Potential Candidate?

CBT-E is one of the major candidates among the individual psychological treatments to be the treatment of choice in all-age eating disorder services. CBT-E was initially developed for adults to treat most forms of eating disorders [7] but has been adapted for adolescent patients [8] with promising results [9]. Moreover, a study found that not only is adolescent CBT-E well tolerated by many young patients, but good outcomes may be achieved even more rapidly than in adults [10].

In CBT-E, parents are actively involved in creating an optimal family environment for facilitating the patient's change and, in agreement with the young person, in supporting them in implementing some treatment procedures. The role of parents as *helpers*, rather than *controllers*, as generally is recommended in family treatments, seems particularly suitable for the need of the young with eating disorders who are in the transitional age and are highly concerned about difficulties concerning control and autonomy.

Another essential characteristic making CBT-E a potential treatment of choice for all-age eating disorder services is that it has been effective for all ages and eating disorders. Therefore, clinicians who treat eating disorders need to learn a single evidence-based psychological intervention rather than many age and eating disorder-specific therapies.

The effectiveness of CBT-E in transition-age youth has been recently supported by a recent study that evaluated the outcome of 115 patients with anorexia nervosa aged 14 to 25 treated with this treatment in a real-world setting [11]. The study showed that patients who finished the programme (62.6%) had considerable weight gain and reduced scores for clinical impairment, and eating-disorder and general psychopathology. Changes remained stable at 20 weeks. A comparison between adolescent and adult patients indicates similar improvements in eating-disorder psychopathology. These data support the strategy of overcoming the problems associated with transitioning from child-adolescent eating disorder clinical service to adult eating disorder clinical services with treatments, like CBT-E, available for the transitional youth age.

In conclusion, CBT-E is a well-accepted and promising treatment that could be adopted to ensure continuity of care for individuals with eating disorders across the transitional age.

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