Psychiatrist discusses guidelines for treating teens' eating disorders

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Eating disorders have been described in medical literature since the 1870s, but until now there have been no guidelines that codify the best way to treat adolescents affected by these conditions—only guidelines for adults.

James Lock, MD, PhD, professor of psychiatry and behavioral sciences at the School of Medicine and director of the Comprehensive Eating Disorders Program at Lucile Packard Children's Hospital Stanford, recently co-authored the first set of evidence-based guidelines for the treatment of eating disorders in teens. He talked with writer Erin Digitale about the rationale for the new guidelines, which were published in the May issue of the *Journal of the American Academy of Child & Adolescent Psychiatry*.

Q. Why was a formalized set of guidelines needed?

Lock: There have never been practice parameters that address eating disorders in children and adolescents, and expertise in treating these disorders has been sort of sequestered. Yet eating disorders are so prevalent and are such a severe problem: Lifetime prevalence in adolescent girls is around 1 percent, and the disorders have among the highest fatality rates of all mental illnesses.

Teens need treatment approaches that account for their level of physical and emotional development, the fact that their parents generally want

and need to be involved in their recovery, and the fact that they have not usually had eating disorders for as long as adult patients with the same diagnoses.

In addition, so many training programs in psychology and psychiatry don't really give opportunities for training in how to treat eating disorders. It's a terrible limitation of many training programs; they should all provide opportunities for learning about eating-disorder patients in a systematic way. I hope the new practice parameters will help facilitate that.

The fact that these guidelines were very thoroughly vetted should give caregivers confidence in them. There is consensus around these recommendations. Practice guidelines also become really important metrics for insurers when they're thinking about what to pay for and how to organize care.

Q. There is a long history of removing young patients from their families as part of treatment for eating disorders, particularly anorexia nervosa. But that's not what the new parameters recommend. Why the shift?

Lock: For many decades, the idea was that to treat eating disorders—especially anorexia nervosa, which has had a specific diagnosis since 1874—it was necessary for medical and psychiatric reasons to take children out of their usual lives and put them in the hospital for long periods. But over the last 15-20 years, we've seen emerging alternatives, such as day and outpatient programs that are family-based. Research now shows that there's no difference in outcome between the two types of treatment. That doesn't mean inpatient treatment is not useful, but on average it's not better.

That's really important because the costs and harms of putting a 14-year-old in the hospital for months at a time are significant. And we also know that most people, when they get better, learn the most from therapy in the context of real life, where they can learn to manage the challenges they'll encounter in dealing with family, school and so on.

So our recommendation is that outpatient treatment is the first line of treatment. It's a strong statement that runs contrary to the history of treating kids and adults who have anorexia nervosa with prolonged hospitalization.

Q. When families are involved in their child's eating-disorder treatment, what are they actually doing and how do they learn what to do?

Lock: Families should be involved in the care of their children with any illness, including eating disorders. The odd thing was leaving parents out in the first place. At our Comprehensive Eating Disorders Program, parents help their children by learning how to prevent eating-disordered behaviors and promote normalized eating, and do so in a supporting and loving fashion. Because the behaviors and thinking associated with eating disorders are often not well-understood by parents, our team of professionals helps parents learn how to address them.

Q. The new edition of the diagnostic and statistical manual of mental disorders, the DSM-5, included some changes to diagnostic criteria for eating disorders. How do these fit together with the new practice parameters?

Lock: The changes to the DSM don't really change recommendations for

care. But what's important about the DSM-5 is that it allows people who treat children and adolescents to diagnose them with eating disorders more accurately. You don't have to use adult metrics, and there is latitude to take parental perspective in mind, for example. So, for instance, an adolescent girl who meets most criteria for anorexia nervosa but has missed two menstrual periods instead of three, or a teen who has most characteristics of bulimia but is purging once a week instead of four times a week can be diagnosed. It allows caregivers to better map treatments onto the guidelines we've developed. Clinicians have written a lot about the need for the diagnostic modifications that are included in the DSM-5, and we're very happy about most of those changes.

Q. What take-away messages do you want physicians or other caregivers to get from the new parameters?

Lock: First, that outpatient treatment is the best line of attack for treating childhood and adolescent eating disorders. Intensive interventions such as hospitalization should be reserved for patients who don't respond to first-line therapies. Second, medication is definitely not a strategy that we know to be useful for children or adolescents who have anorexia nervosa or bulimia nervosa. Clinicians should think carefully about their reasons for prescribing psychiatric medications to these patients. Finally, we want people to be reminded that these disorders are very prevalent and serious, and that it's important to learn about how to take care of these kids.

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