

Recent advances in therapies for the eating disorders

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Abstract

In the first part of this decade, many reviews of the impact of treatments for the eating disorders were conducted, with broadly similar conclusions. This review provides an update on progress (or otherwise) in the field over the past three years.

Introduction and context

The eating disorders have proven a challenge for clinicians since they were first identified. Such patients often have physical safety needs as a priority, and then require effective therapy for the eating disorder itself. This review focuses on recent developments in the latter part of that process – treatment for the eating pathology. Many authoritative treatment reviews have been published in recent years [1-7], based on synthesis of both the empirical evidence and expert clinical experience. They include recommendations for both physical safety and therapies, and have been relatively consistent in their conclusions. Their key empirical findings regarding therapies for the eating disorders are as follows.

For adult sufferers

1. Psychological treatments have relatively low levels of impact on anorexia nervosa, and there is no clear difference in outcome between such treatments.

2. Physical treatments for anorexia nervosa (for example, nutrition or medication) are needed to ensure safety (for example, biological safety or psychiatric risk), but there is no consistent evidence that those treatments have an impact on the anorexia nervosa itself.

3. Psychological treatments for bulimia nervosa and binge eating disorder are relatively effective, with strong evidence for the impact of cognitive behavioural therapy (CBT) and interpersonal psychotherapy (the former being faster to take effect than the latter).

4. Antidepressants (particularly fluoxetine) are effective in reducing the level of bulimic symptoms in bulimia nervosa and binge eating disorder, though the duration of the effect may be short-term.

5. Self-help approaches have a relatively low level of impact on the eating disorders, producing little impact on abstinence from behaviours [8].

6. Apart from binge eating disorder, there is little evidence of the impact of treatment for atypical cases (which probably represent the largest number of sufferers [5]).

For younger sufferers

1. There is no clear evidence regarding what works for children.

2. Adolescents with anorexia nervosa benefit more from family-orientated therapies than individual therapies, though there is little evidence for such a difference in bulimic or atypical cases.

Of course, these conclusions should be read alongside the expert clinical opinions that the guidelines use to supplement the evidence base (particularly where there is no real empirical base to rely on).

Recent advances

The past 3 years have yielded significant advances in our knowledge base that are not reflected in these reviews. Some of those advances are in the form of consolidation

of the existing positive evidence, some are new conclusions, and some are disappointingly negative findings. One key finding is that relatively few patients who are referred to specialist services either make it through to treatment or complete that treatment [9]. This finding needs to be taken into account when considering the following advances.

Types of therapy

Motivational enhancement

A number of motivational approaches have been trialled as adjuncts to other therapeutic methods. The recent evidence from this work is mixed, with motivational enhancement therapy proving relatively ineffective for inpatients with eating disorders (leading to little reliable change in motivation or in eating pathology itself) [10]. There is some evidence of increased motivational benefit among binge eaters, though there is less consistency regarding change in their eating pathology [11,12].

Cognitive behavioural therapy

Among bulimic cases, CBT has extended its evidence base considerably [13]. That development parallels improvements in this form of therapy [14,15], although whether CBT is actually applied in broad clinical practice is questionable [16]. It has been shown that CBT can be individualised and applied to patients in non-research settings [17]. The most important finding is an improved outcome with bulimic cases (and comparable outcomes with atypical cases – see below) [18]. There is preliminary evidence that relatively complex cases benefit most from a more complex form of CBT [18] and that some in-patients can benefit from a CBT-based programme [19]. However, CBT remains unproven with relatively low-weight anorexic patients, where physical needs and starvation effects predominate.

Dialectical behaviour therapy

Dialectical behaviour therapy (DBT) has previously been proposed for use with bulimia and binge eating disorder. This stance has been supported by recent work using a version of DBT that is only minimally adapted from the original [20].

Medication

There has been some advance in the field of psychopharmacology for bulimic eating disorders over the past few years, though these findings need replication and extension. First, there is some evidence that fluoxetine is useful for bulimic adolescents [21]. Second, sibutramine may be effective in the treatment of binge eating disorder [22]. Finally, topiramate seems to be effective in the short term for bulimic disorders where there is comorbid obesity [23].

There is no clear evidence for medication in the treatment of the core symptoms of anorexia nervosa, regardless of age [21,24]. There have been some suggestions that olanzapine might be a useful adjunct to other treatments for anorexia nervosa (particularly given its tendency to promote weight gain). However, it is too early to support this contention, given the differing outcomes of recent studies, their methodological weaknesses, and the lack of clarity about the mechanisms that might be involved [25-27].

Specific subgroups of eating disordered patients

Atypical cases

As already identified, atypical cases constitute a very large proportion of the eating disordered population [5], but there has been almost no evidence on their treatment (beyond the subgroup of binge eating disorder patients). This gap has been addressed recently in adults and adolescents. Such cases can be successfully treated using similar methods to those employed with bulimic disorders, with broadly comparable outcomes [17,18,28].

Younger cases

Family-oriented therapies still have a pre-eminent position with adolescents with anorexia nervosa [29]. However, there is now good evidence that both family and CBT approaches are effective for bulimia nervosa in adolescents [30].

Methods of delivery

Self-help

Recent findings in this domain have been uninspiring. A recent review has concluded that self-help for bulimia nervosa and binge eating disorder is beneficial, but only relative to a waiting list control condition. There is little evidence that this approach is more helpful than any active control condition [31].

Electronic delivery

Various researchers have tested electronic methods (for example, via internet, text messages, and CD-ROM) of delivering treatments that are effective when delivered individually. Unfortunately, the results are relatively weak and uptake is poor, leading to the conclusion that this is not yet a method of conducting therapy that can be widely recommended [32,33].

Implications for clinical practice

In brief, recent findings reiterate and extend the role of CBT as the first line treatment for most adult cases of eating disorders (provided the CBT is delivered appropriately), extending its utility to younger cases and to atypical cases, and showing its effectiveness in

non-research settings. However, existing self-help methods and the use of electronic media for delivery of CBT are not supported at present. The role of family therapy for younger cases is also more widely supported. There are more positive findings regarding the use of DBT and medication for bulimic disorders, but medication is not indicated for the core pathology of anorexia nervosa.

Future directions in clinical research in therapies for the eating disorders

Over the next few years, it will be important to monitor the following aspects of the treatment literature in the eating disorders:

1. Continued developments of psychological therapies for bulimic disorders and atypical eating disorders (for example, CBT, DBT), to enhance existing outcomes and to carry these effects further into everyday clinical practice.
2. Treatment outcomes for anorexia nervosa, including psychological and psychopharmacological approaches (findings are anticipated from a number of current trials).
3. The development of psychopharmacological approaches that relate to the psychobiology of the eating disorders (including anxiety structures) [34] that have more extensive periods of follow-up.
4. Psychological therapies that have been proposed to be valuable but where the evidence base is minimal should be tested more fully in order to demonstrate whether or not they meet the criteria for evidence-based practice.
5. The matching of psychological therapies to individuals, to ensure that individuals are offered the most effective treatment for their individual problem [18].
6. Working via carers, addressing both their own stress and making them more able to work as members of the broader team treating the sufferer [35].
7. The determination of whether treatment effects generalise across settings (for example, do therapies for restrictive problems tested in outpatient settings work as well in day- and in-patient settings?).

Abbreviations

CBT, cognitive behavioural therapy; DBT, dialectical behaviour therapy.

Competing interests

The author declares that he has no competing interests.

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