Ethical Challenges of Treating Adolescent Patients with Eating Disorders as They Transition to Adulthood

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ABSTRACT

Eating disorders are defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as a persistent disturbance of eating that impairs health or psychosocial functioning.[1] The treatment of eating disorders typically brings up several ethical challenges, particularly in adolescents as they are transitioning into making their own healthcare decisions. The aim of this manuscript is to explore several topics that have sparse literature including: how the treatment of eating disorders differs between adolescents and adults, capacity and the right to decline treatment in the setting of eating disorders, involuntary treatment of eating disorders, the ethics of using restraints in eating disorder treatment, and how to prepare adolescents with eating disorders for the transition into adult medical care. With mental health diagnoses on the rise, ethics consultation teams may be challenged with consultations regarding declination of treatment and transitions of care in this population.

BACKGROUND

- Anorexia nervosa is a relatively rare disease that affects 0.6% of adults and 0.3% of adolescents, with a median age of onset of 18 years.[1]
- The pathophysiology of anorexia nervosa is largely unknown.[1]
- Anorexia Nervosa is characterized by either restricting subtype or binge and purging subtype.[1]
- The treatment of choice for anorexia nervosa in adolescents is family-based therapy.[2]
- There are several treatment modalities that have shown moderate efficacy for treatment of adult anorexia nervosa including enhanced cognitive based therapy, focal psychodynamic psychotherapy, specialist supportive clinical management, and the Maudsley model of anorexia nervosa treatment for adults, though none of these treatment modalities are as effective as family-based therapy in adolescents.[3]
- Bulimia nervosa affects 1% of adults and 0.9% of adolescents, with a median age of onset of 18 years.[1]
- The pathophysiology of bulimia nervosa is also largely unknown, though there may be contribution from abnormal functioning of the corticolimbic circuit, which is involved in appetite regulation.[1]
- Enhanced cognitive behavioral therapy has been found to be the most efficacious psychological treatment for bulimia nervosa, though some evidence suggests family-based therapy is superior for adolescents with bulimia nervosa.[4,5]
- Patients with eating disorders frequently suffer from comorbid mental illness including personality disorders, anxiety disorders, obsessive compulsive disorders, post-traumatic stress disorder, depression, substance use disorders, impulse control disorder, and conduct disorder.[6]
- There are no pharmacological treatments for anorexia nervosa, though some antidepressants such as SSRIs, TCAs, and monoamine oxidase inhibitors may be efficacious in improving symptoms of bulimia nervosa.[7]

TABLE 1

DSM-5 Diagnostic Criteria of Anorexia Nervosa and Bulimia Nervosa[1]

Anorexia Nervosa	Bulimia Nervosa
Restriction of energy intake leading to body weight that is less than minimally normal for age, sex, developmental trajectory, and physical health.	Recurrent episodes of binge eating characterized by the following: a) Eating any amount of food that is larger than most people would eat during a similar time period under similar circumstances. b) Lack of control of eating during the episode.
Intense fear of gaining weight or persistent behavior that prevents weight gain.	Recurrent inappropriate compensatory behaviors to prevent weight gain. Examples include self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; excessive exercise; fasting.
Disturbance in the way one's body is perceived, extreme influence of body on self-evaluation, or lack of recognition of seriousness of low body weight.	Binge eating and compensatory behaviors occur, on average, once weekly for three months.
	Extreme influence of body on self-evaluation.
	The disturbance does not occur exclusively during episodes of anorexia nervosa.

TREATMENT HESITATION

- Eating disorders are particularly difficult to treat as patients are typically hesitant to receive treatment given their values are so intertwined with the disease itself.
- Involuntary treatment is often considered, especially in adolescents or adults whose disease is so severe they are thought to lack capacity to decline treatment.
- Involuntary treatment in the case of severe eating disorders may include forced feeding, the use of restraints, or involuntary admission to a locked ward.[8]
- Data surrounding efficacy and long-term outcomes of involuntary treatment is lacking in part because it is challenging to fully understand the long-term outcomes of involuntary treatment as those who receive involuntary treatment typically have more severe disease and therefore may have a worse prognosis regardless if their treatment is voluntary or involuntary.[9]
- Blikshavn et al in 2020 looked at 5-year outcomes in patients that were physically restrained for meals. It was reported that those who were physically restrained for meals had higher rates of persistent symptoms at 5-years, though there was no difference in readmission rates or BMI compared to those who were never physically restrained for meals.[10]
- In situations of declining treatment in patients with capacity, clinicians should consider using a harm reduction model.

CAPACITY

- An adult with capacity can decline treatment, including life-saving treatment. This right is only challenged if patient has significant cognitive, physical or psychological impairment. In order to have capacity, one must be able to understand the risks and benefits of each treatment option (including no treatment), clearly communicate their decision, and demonstrate logic and consistency of decision with personal values and goals.[11]
- In the case of severe eating disorders, there is often concern that there is significant enough psychological impairment preventing patients from having capacity to decline treatment. Additionally, severe malnutrition can lead to cognitive impairment impacting capacity.
- In many states adolescents can consent to mental health treatment. One could argue if they have the reasoning and cognitive ability to give informed consent, they also can decline treatment, though medical providers are often concerned they lack the experience to understand the long-term consequences of their decisions.

TRANSITION TO ADULTHOOD

- There are key differences in the treatment of eating disorders in a pediatric setting compared to an adult setting, which presents adolescents with a unique challenge as they are transitioning into adulthood. Adolescents are coming from a setting in which they had minimal autonomy and their parents made many of their decisions for them into a setting where patient autonomy is heavily valued.
- Transition of care should happen based on developmental readiness, not just age.[12]
- Providers and families should work towards gradually increasing the patient's responsibility for eating and weight restoration while still in adolescent care, rather than shifting the responsibility to the patient all at once when they transition to adult care.[12]
- A period of parallel should be conducted, which allows the young adult to continue receiving support and assistance from their pediatric provider as they work towards developing a therapeutic relationship with their new adult treatment team.[13]

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