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.1
- 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.1
- 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.6,11
- 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.6,11
- 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

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.1
- Involuntary treatment is often considered, especially in adolescents or adults whose disease is so severe they are thought to lack capacity to decline treatment.1
- Involuntary treatment in the case of severe eating disorders may include forced feeding, the use of restraints, or involuntary admission to a locked ward.4
- 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.2
- 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.5

REFERENCES