

Adolescent Crises

This next section addresses those crises in adolescence which are more chronic and aberrant than typical for the average adolescent. Adolescents who experience a crisis that requires mental health treatment do not constitute the norm; rather, they are in the minority. A discussion of all the potential problems of non-clinical significance which might befall a typical adolescent is beyond the scope of this chapter; issues related to school underachievement, family conflict, and other challenges to the mastery of adolescent developmental tasks are left to chapters on adolescent development rather than to those devoted to adolescent crises. Instead, the following narrative and case examples focus on three crises which often are associated with the adolescent stage: eating disorders, suicide, and non-suicidal self-injury (NSSI; aka: cutting). Another case regarding identity development is included here as well, not because it is a crisis in the magnitude of the aforementioned three, but because it represents a challenge common to many adolescents.

Eating Disorders

An eating disorder is a psychological disorder which is characterized by an excessive desire to be thin as well as an intense fear of gaining weight. Individuals with the disorder limit their food intake to health-threatening small amounts, or use other techniques (excessive exercising, laxatives, diuretics, and vomiting) as weight control strategies. Eating disorders tend to be placed into three categories: anorexia nervosa, bulimia nervosa, and binge-eating disorder. A summary of the diagnostic criteria for each disorder contained in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*) follows:

Anorexia Nervosa

- Intense fear of gaining weight or becoming fat
- Significantly low weight that is less than minimally expected for adolescents
- Disturbance in view of body weight/body image
- Persistent lack of recognition of the seriousness of the low body weight

DSM-5 considers two types on anorexia. In the restricting type, the individual focuses on weight loss primarily through dieting, fasting, or excessive exercise. However, the binge-eating/purging type of individual maintains the weight loss through recurrent episodes of binge-eating, then purging, either by self-induced vomiting, or overusing laxatives, diuretics, or enemas. Despite their obsession with weight gain, those with this disorder do experience hunger pains.

Bulimia Nervosa

- Recurrent episodes of binge eating
- Recurrent compensatory behaviors to prevent weight gain through self-induced vomiting; overuse of laxatives, diuretics, or other medications; fasting; or excessive exercise
- These behaviors occur, on average, once a week for three months
- Body shape and weight has undue influence on self-image

According to the *DSM-5*, to meet the criteria for bulimia, the binge eating must be done within a specific period of time (i.e., two hours) and must include an amount of food that is much more than what most individuals would eat during that same time period. Additionally, the individual must have a sense of lack of control over the eating during that period; that is, a sense that one cannot stop eating or control the amount of food being eaten.

Binge-Eating Disorder

- Recurrent episodes of binge eating characterized by the bulimia nervosa criteria described above
- Episodes are associated with at least three of the following: eating much more rapidly than usual, eating although feeling uncomfortably full, eating large amounts without being hungry, eating alone to avoid embarrassment, feeling depressed, disgusted, or guilty after episodes
- Distress experienced during binge eating episodes
- Binge eating occurs at least once per week for three months

Research suggests that 15% of young adult females and 6% of young males are affected by eating disorders. Those with the restricting type of anorexia limit their intake of food to the point where they experience starvation, whereas the binge-eating and purging types use various inappropriate compensatory behaviors like self-induced vomiting after they eat. The emaciated appearance of individuals with anorexia is an external indicator of the disorder. Bulimia is diagnosed twice as often as anorexia, and bulimia sufferers are more likely to seek out treatment.

There are more estimates of the prevalence of eating disorders than there are actual statistics, particularly among adolescents, since most individuals who suffer with eating disorders keep them secret and fail to acknowledge their symptoms. Therefore, survey data may reveal only a minimal estimate of the disorder, considering the large number of unreported cases. Another confounding problem in determining the prevalence of eating disorders is the number of adolescents, primarily female, who do not exhibit all the diagnostic indicators of the disorders as determined by the *DSM-5*, yet who exhibit disordered eating habits and other excessive dieting regimens.

Estimates of the number of those adolescents actually diagnosed with an eating disorder are approximately 1% for anorexia, 4% for bulimia among college-age women, and 1% for binge eating (Anorexia Nervosa and Related Eating Disorders [ANRED], 2004). Earlier estimates (Polivy & Herman, 2002), however, placed the number at between 3 to 10% of women between the ages of 15 to 29.

Documenting this larger number was the YRBSS survey that, in tracking all health-risk behaviors of adolescents, also surveyed the dieting practices of this age group. Some of its findings among adolescent females and their attempts to lose weight are listed below:

- 31.5% described themselves as overweight (higher among females at 38.2% than males at 25.3%)
- 13.9% reported obesity
- 45.6% reported that they were trying to lose weight (higher among females at 60.6% vs males at 31.4%)

- 60% had exercised to lose weight
- 17% had gone for 24 hours or more without eating
- 8.1% had taken diet pills, powders, or liquids without a doctor's advice within 30 days of the survey
- 6.2% had vomited or taken laxatives in the last 30 days

The health risks involved with eating disorders are significant: irregular heartbeat, liver and kidney damage, loss of tooth enamel and damage to the esophagus due to excessive vomiting, loss of muscle mass and of the menstrual cycle, a weakened immune system, and anemia and malnutrition. Additional psychological effects include depression, anxiety, guilt and shame, a sense of hopelessness and helplessness, and suicidality.

Case Presentation: Danielle, A Story of Anorexia

For Danielle, it all started as a 12-year-old seventh grader who had just entered the middle school in her local district. A sensitive girl conscious of her appearance and of her body shape, she began what was to be years of food restricting in an attempt to get to and maintain a weight that seemed to her to be reasonable; one that was more comparable to the tall, thin young girls with whom she danced. However, to her friends and to her teachers, there was nothing reasonable about her weight status; they brought it to her attention and explained to her this thing called anorexia nervosa, but Danielle didn't think that that problem applied to her at all. Changes in her life over the years of her disorder were stressful for her and made it difficult for her to maintain a normal weight: her family's move in the eighth grade to a different town, the death of a close grandfather, and finally the death of her own mother after a long struggle with cancer.

When she entered the tenth grade, her thin frame didn't escape the notice of her friend's mother who promptly called Danielle's mother to express her concerns. Her first appointment with a psychologist who specialized in the treatment of eating disorders followed after her mother confronted her about her food restriction. Danielle saw the psychologist only once, preferring not to return to him after he attributed her eating disorder to anger at her parents for the forced middle school relocation, a conceptualization with which she strongly disagreed. However, she did see another therapist on a regular basis along with a nutritionist who developed a meal plan for her and supervised her adherence to it.

Although she continued in therapy, she got better at lying about her dietary habits, even to her therapist. She even went so far as to put things in her pockets so that she would be heavier at her regular weigh-ins. Her charade was over, however, when, as a 15-year-old tenth grader, she passed out on the way to her first period class. Helped up by her friends and escorted to the class, Danielle recalled not remembering much for the next few minutes until the school nurse arrived with a wheelchair and took her to her office. A call to Danielle's parents summoned them to school where they took her to the first of many hospitals she was to visit in the next few years.

Visits to inpatient units, outpatient units, day treatment programs, and partial hospitalization programs became part of her routine through her high school years and beyond. At the end of her 11th grade when her mother was diagnosed with brain cancer, she completely fell apart, eating no solid food for 18 straight days; all that sustained her was water and coffee with a little milk.

Case Conceptualization/Crisis Resolution

Now several years into recovery, Danielle can reflect on her journey through her anorexia. She can speak of it publicly and has, in fact, become a leader of a support group at a local eating disorder treatment center. She also is nearing completion of a graduate program in social work with further plans to obtain her license as a clinical social worker so that she can become a therapist for others with eating disorders. "I want to raise awareness; it helps keep me in recovery."

In the following interview, she provides some insight and some advice for those who treat eating disorders and for other adolescents themselves. Unlike other cases in this book, the following exchange between Danielle and her counselor provides a retrospective rather than an interventionist look, on the early stages of her anorexia.

Counselor: We all know what the research says about the personality type of the individual who develops an eating disorder. Tell me what you were like as a young person.

Danielle: I was just a typical kid. I was teased by the proverbial school bullies just like everyone else my age, but I took it more personally than the others. It always bothered me more.

C: Tell me when things started to change for you.

D: In grade seven when I was 12-years-old, things were important; looks became important, clothes were important, all those shallow things. I didn't want to wear glasses, and my shoes and everything had to be a brand name.

C: Middle school can be a significant transition for young adolescents. Was that transition a smooth one for you or a difficult one?

D: It was around that time that things started to change for me. I started gaining weight, but not growing taller; I was a little pudgy, maybe at most, 10 pounds overweight.

C: Was that a problem for you?

D: It wasn't only that. I had been a dancer from ages three through 15 or 16, and I started to compare my body to other dancers' bodies, those tall, lean bodies. My stomach was a sore issue, then my thighs. I could never have a flat enough stomach.

C: What did you do about these thoughts and feelings?

D: Well, I decided that perhaps a diet was in order, so I cut back drastically on my food intake. I stopped eating breakfast and lunch completely. I was unable to avoid having dinner with my family, so I had to eat at that time in order to keep from arousing suspicion in my parents.

C: Was there a change in your eating habits after you moved with your family to a new town? I know that you were angry over having to leave your friends behind, and you were now an eighth grader.

D: I just added new tricks to my dieting. I still refused to eat any breakfast or lunch, and I avoided dinners