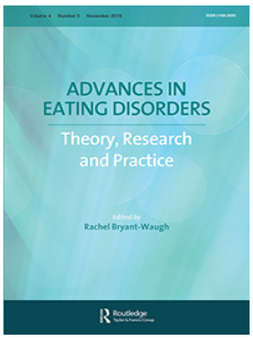

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Advances in Eating Disorders

Theory, Research and Practice

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EDITORIAL

Advances in eating disorders

I recently received an email from a young professional who had been treated in our hospital for an eating disorder nearly 20 years ago. Around the same time as she was under our care, founding editor of *Advances in Eating Disorders*, Bryan Lask and I, together with Bryan's friend and colleague Isky Gordon and some other colleagues, published a paper entitled 'Childhood onset anorexia nervosa in children – towards identifying a biological substrate' (Gordon, Lask, Bryant-Waugh, Christie, & Tamimi, 1997). In 1997, our in-patient unit was busy and we were working with families experiencing extremely challenging times as they and their children struggled with anorexia nervosa. We recognised that our attempts to assist in this process, although well-intentioned and as far as possible guided by what we knew from reading and experience worked best, were hampered by woefully inadequate understanding of the aetiology of this destructive condition.

By then, a good 10 years into running a specialist eating disorders service for children and young adolescents, we had built up a modest but respectable publication record. Our papers had discussed recognising eating disorders in the younger population; we had outlined tools to assess and describe psychopathology in an age-appropriate manner; we had explored correlates and conducted follow-up and outcome studies; we had commented on the seriousness of anorexia nervosa in this age group and we had advised about monitoring of progress. We had not, however, published anything of substance relating to the central issue of aetiology; targeting treatment to known causes remained elusive.

Our 1997 article was based on a small study involving 15 young people between the ages of 8 and 16 years treated on our unit for anorexia nervosa. All consented, with parental agreement, to undergo regional cerebral blood flow radioisotope scans, and three of them agreed to a follow-up scan when their weight had returned to normal. The findings of the study revealed that 87% (13 of the 15) were identified as having unilateral temporal lobe hypoperfusion, which was also seen in the 3 girls who had a follow-up scan after weight restoration. We commented that the study was the first to report on reduced regional cerebral blood flow in childhood-onset anorexia nervosa, and suggested that this may point to an underlying primary functional abnormality (Gordon et al., 1997). We cautiously stated that 'The etiology of anorexia nervosa is not fully understood, but is probably multifactorial, including a biological substrate'.

Meanwhile, we were treating our patients with a combination of experienced nursing care and milieu type therapy on the in-patient unit, with concurrent family therapy and individual work. The young professional who recently contacted me wrote that she had wanted to contact Bryan Lask for some time to let him know how much she appreciated, and continues to appreciate, the support he gave 20 years ago at the most difficult times. She recalled family therapy sessions with Bryan and myself and said that she was 'so entrenched in the struggle at the time' that thanks were not forthcoming.

It is a strange thing – we do not do our work in order to receive expressions of gratitude, indeed, most of us are very familiar with the sheer awfulness of day-to-day existence for people suffering from eating disorders and for their loved ones. Why would anyone say

thank you when you are an integral part of that daily anxiety, misery and despair? Our role is to do the absolute best we can, to be bearers of hope and to fight alongside our patients and their families – to hang on in there on a very rough ride. If we are completely and truthfully honest, we are rarely certain that what we are doing is the 'right' thing. We must work together – the individual, those close to them and ourselves as a team – to ensure optimal likelihood of recovery. For our part as clinicians, helping someone successfully move along that path is not borne out of our knowledge of theory and facts, our command of research findings or our proficiency in adhering to treatment protocols. It is of course built on such things, but I believe the truly vital ingredients are humanity, honesty, openness and flexibility. Each person we see deserves fresh attention; the 'etiology of anorexia nervosa' remains 'poorly understood' 20 years on and under those circumstances we must continue to seek to understand, to improve our knowledge and to offer the best evidenced treatments. This has been the central theme of *Advances in Eating Disorder: Theory, Research and Practice,* but it is the glue that holds these together – humanity, honesty, openness and flexibility – that allows true advances to take hold.

And as a human clinician, how wonderful to receive that email and read*:*

> After many years of battling, I am now thriving and loving life. Thank you with all of my heart, and I know these thanks would be echoed by my parents and siblings. No amount of words or gratitude could ever explain the debt I owe to you.

There is no debt, just joy for each life recovered and a collective determination, as evidenced in the pages of this Journal, to continue to move forward.

Reference

Gordon, I., Lask, B., Bryant-Waugh, R., Christie, D., & Tamimi, S. (1997). Childhood onset anorexia nervosa in children – towards identifying a biological substrate. *International Journal of Eating Disorders*, *22*, 159–165.

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