Child and Adolescent Eating Disorders: Diagnoses and Treatment Innovations

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Agenda

1. DSM-5 eating disorders in youth
2. Assessment of eating disorders
3. Unifying principles for treatment of eating disorders in youth
   – Family-based treatment
   – Cognitive-behavioral therapy for ARFID
4. Conclusions
Anorexia Nervosa

Bulimia Nervosa

Eating Disorder Not Otherwise Specified

DSM-IV (1994)
\textbf{DSM-IV (1994) \rightarrow DSM-5 (2013)}

**DSM IV**
- Anorexia Nervosa
- Bulimia Nervosa
- Eating Disorder Not Otherwise Specified

**DSM-5**
- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Other Specified Feeding or Eating Disorder
- Unspecified Feeding or Eating Disorder
- Avoidant/Restrictive Food Intake Disorder
- Atypical Anorexia Nervosa
- Subthreshold Bulimia Nervosa
- Subthreshold Binge Eating Disorder
- Purging Disorder
- Night Eating Syndrome
- Other
- Pica
- Rumination Disorder
# Lifetime Prevalence of Eating Disorders

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
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<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
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<tr>
<td>Anorexia nervosa</td>
<td>.3</td>
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<tr>
<td>Bulimia nervosa</td>
<td>.5</td>
<td>1.3</td>
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<tr>
<td>Binge eating disorder</td>
<td>.8</td>
<td>2.3</td>
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Hudson et al., 2007; Swanson et al., 2011
Common presentations in youth

Anorexia nervosa

Avoidant/restrictive food intake disorder (ARFID)
**DSM-5 Diagnostic Criteria**

**Anorexia nervosa**

A. Low body weight

B. Fat phobia OR weight loss behaviors

C. Body image disturbance
   - Subtypes: Restricting or Binge/purge
   - Specifiers (by BMI):
     - Mild, moderate, severe, extreme
     - Partial or full remission

**ARFID**

A. Failure to meet nutritional needs:
   1. Weight loss
   2. Nutritional deficiency
   3. Dependence on enteral or oral supplements
   4. Psychosocial impairment

B. Not due to lack of food

C. No body image disturbance

D. Not better explained medically
Although both involve restrictive eating, ARFID differs from AN

Becker et al., 2016, ICED

N = 123 male and female patients (ages 10-78yo) with restrictive eating disorders at the MGH EDCRP
Although both involve restrictive eating, ARFID differs from AN

\[ p < .05 \]

\( N = 123 \) male and female patients (ages 10-78yo) with restrictive eating disorders at the MGH EDCRP

Becker et al., in preparation
Both Eating Disorders are Characterized by Restrictive Eating

• But, in anorexia nervosa, restriction is motivated by drive for thinness and fear of fatness, whereas in ARFID, restriction is not due to shape and weight concerns.
SCOFF Questionnaire:
“Yes” to 2+ indicates likely ED (AN Screen)

Do you make yourself Sick because you feel uncomfortably full?
Do you worry you have lost Control over how much you eat?
Have you recently lost Over 15 pounds in a 3-month period?
Do believe yourself to be Fat when other say you are too thin?
Would you say that Food dominates your life?

Morgan et al., 2009
NIAS (Nine Item ARFID Screen): “Yes” to 2+ indicates likely ED

1. I am a picky eater
2. I dislike most of the foods that other people eat
3. The list of foods that I like and will eat is shorter than the list of foods I won't eat
4. I am not very interested in eating; I seem to have a smaller appetite than other people
5. I have to push myself to eat regular meals throughout the day, or to eat a large enough amount of food at meals
6. Even when I am eating a food I really like, it is hard for me to eat a large enough volume at meals
7. I avoid or put off eating because I am afraid of GI discomfort, choking, or vomiting
8. I restrict myself to certain foods because I am afraid that other foods will cause GI discomfort, choking, or vomiting
9. I eat small portions because I am afraid of GI discomfort, choking, or vomiting.

Zickgraf & Ellis, 2018
Unifying Principles in Treatment of Child and Adolescent Eating Disorders

- cBt (emphasis on the Behavior change)
- Parent involvement, especially when weight is low
- Short-term, structured intervention
  - Family-based treatment for AN
  - Family-assisted or individual CBT-AR for ARFID
Family-Based Treatment for Adolescents

- Basic principles
  - AN is developmental setback
  - Parents must step in to interrupt symptoms that patient cannot control
- Three phases
  1. Parents re-feed child
  2. Child eats independently
  3. Return to normal development

FBT Manual
Lock et al., 2001

www.mghcme.org
FBT Phase I: Parents Re-feed Child

- Therapist absolves parents of self-blame
- Parents and patient eat all meals together as a family
- Separate patient from ED

*Parents encourage “one more bite”*

*Parents choose energy-dense foods*
FBT Phase II: Child Eats Independently

- Patient gradually begins to eat meals away from parents
- Therapist tries to differentiate patient’s identity from the ED
- Family explores how AN has affected family relationships
FBT Phase III: Return to Normal Development

- Patient eats most meals on her own and selects foods
- Therapist supports patient’s separation from her parents as age-appropriate
- Family remains vigilant for signs of relapse

Increase emphasis on socializing

Family prepares for separation
How Well Does FBT for AN Work?

Randomized Clinical Trial Comparing Family-Based Treatment With Adolescent-Focused Individual Therapy for Adolescents With Anorexia Nervosa

Lock et al., 2010
4 Stages of CBT-AR

1. Psychoeducation and regular eating
2. Treatment planning
3. Address maintaining mechanisms in each ARFID domain
   a. Sensory sensitivity
   b. Fear of aversive consequences
   c. Lack of interest in food or eating
4. Relapse prevention
Tailoring CBT-AR to the Patient

**Example Presentation #1:** ARFID with 1 maintaining mechanism; not underweight

- **Stage 1**
- **Stage 2**
- **Stage 3**
- **Stage 4**

  Address single maintaining mechanism

**Example Presentation #2:** ARFID with 2 maintaining mechanisms; not underweight

- **Stage 1**
- **Stage 2**
- **Stage 3**
- **Stage 4**

  Address 2 maintaining mechanisms sequentially and in order of priority

**Example Presentation #3:** ARFID with 3 maintaining mechanisms; underweight

- **Stage 1**
- **Stage 2**
- **Stage 3**
- **Stage 4**

  Additional time to initiate weight restoration

  Address 3 maintaining mechanisms sequentially and in order of priority
Two formats

• Family-supported CBT-AR
  – Child and early adolescent patients (10-15yo)
  – Young adult patients (16yo+) who live at home and have significant weight to gain

• Individual CBT-AR
  – Late adolescent and adult patients without significant weight to gain (16yo+)

• Though session attendees differ, interventions are similar across the age span
CBT-AR: Stage 1

- Psychoeducation on ARFID
- Self- or parent-monitoring
- Regular eating
- Personalized formulation
- *If underweight:*  
  - Begin to restore weight by increasing volume of preferred foods  
  - Conduct in-session therapeutic meal to provide coaching
- *If not underweight:*  
  - Make small changes in presentation of preferred foods and/or reintroduce recently dropped foods
CBT-AR: Stage 2

- Identify foods that could correct nutrition deficiencies
- Select new foods to learn about in Stage 3
CBT-AR: Stage 3
Sensory Sensitivity Module

• Select foods to learn about that
  – Increase representation from 5 food groups
  – Correct nutritional deficiencies
  – Reduce psychosocial impairment

• *Early sessions*: Repeated exposure to very small portions

• *Later sessions*: Incorporate larger portions into meals and snacks to meet calorie needs
CBT-AR: Stage 3
Fear of Aversive Consequences Module

- Provide psychoeducation on how avoidance increases anxiety
- Create exposure hierarchy to include small steps leading up to food or eating-related situation that led to initial avoidance
- Continue exposures until patient has completed the most distressing task on the hierarchy
CBT-AR: Stage 3
Lack of Interest in Food or Eating Module

- Interoceptive exposures to increase tolerance of physical sensations:
  - **Fullness**: Rapidly drink several glasses of water
  - **Bloating**: Push belly out
  - **Nausea**: Spin in chair

- Self-monitoring to increase awareness of hunger and fullness

- In-session practice with highly preferred foods
CBT-AR: Stage 4

• Evaluate treatment progress
  – Patients unlikely to become “foodies,” even if treatment is successful
  – CBT-AR is designed to expand diet, restore weight, correct nutritional deficiencies, and reduce psychosocial impairment related to ARFID

• Co-create relapse prevention plan
  – Identify CBT-AR strategies to continue
  – Set goals for continued progress
How Well Does CBT-AR Work?

- Patient no longer meets criteria for ARFID and/or symptom severity has decreased
- Patient eats and incorporates several foods in 5 food groups
- Patient’s growth (height and weight) has increased to that expected
- Nutritional status is replete
- Patient no longer experiences clinically impairing psychosocial consequences
How Do Patients Define Recovery?

“…food and my body are only parts of who I am. Neither defines me anymore.”

“My life became more full, and there just wasn’t room on my plate for the eating disorder anymore.”
To refer patients to studies...

- We are recruiting girls ages 10-22yo
  - With low-weight eating disorders (<90% of expected body weight)
  - Healthy controls (no psychiatric comorbidities)
  - Must travel to Boston

- For more information, please contact our study NP, Meghan Slattery
  - Email: mslattery@mgh.harvard.edu
  - Phone: (617) 643-0267
To refer patients to studies...

- We are also recruiting boys and girls ages 10-22yo
  - With ARFID and ARFID-like symptoms
  - Healthy controls (no psychiatric comorbidities)
  - Must travel to Boston

- For more information, please contact our study NP, Elisa Asanza:
  - Email: easanza@partners.org
  - Phone: (617) 726-9394
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