Eating Disorders – Recognition, Intervention, and Working With Families

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I have no conflict of interest.

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Outline

Recognition
- Diagnostic Criteria
- Epidemiology and Comorbidity

Intervention
- Team Approach to Clinical Care
- Psychotherapy
- Medication

Working With Families
- Family Based Treatment
- Intensive Family Treatment
Recognition
Which One Of Your Patients Has An Eating Disorder? Could You See It?
Anorexia Nervosa - DSM-5 Criteria
Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5

1. Restriction of energy intake relative to requirements, significantly low body weight in the context of age, sex, developmental trajectory, and physical health.

1. Intense fear of gaining weight or becoming fat, even though underweight.

2. Disturbance in the way one's body weight or shape are experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight.
Bulimia Nervosa, DSM-5 Criteria

1. Recurrent episodes of binge eating, sense of lack of control over eating

2. Recurrent behavior to prevent weight gain
   - **Self-induced vomiting**; misuse of laxatives, diuretics, enemas, medication, fasting, excessive exercise …

3. At least once a week for three months.

4. **Self-evaluation is unduly influenced** by body shape, weight

5. Not occur exclusively during anorexia nervosa.
Binge Eating Disorder - DSM-5 Criteria (New)

1. Recurrent episodes of binge eating
2. Associated with
   - eating much more rapidly than normal
   - until feeling uncomfortably full
   - when not feeling physically hungry
   - eating alone
   - feeling disgusted, depressed, guilty
3. Marked distress regarding binge eating
4. On average, at least once a week for three months.
5. Not associated with another eating disorder
Other Specified Eating Disorders (OSFED)
DSM-5 Criteria (New)

1. Anorexia Nervosa Not Meeting Underweight Criteria
2. Bulimia Nervosa of Low Frequency and/or Limited Duration
3. Binge Eating Disorder of Low Frequency and/or Limited Duration
4. Purging Disorder
5. Night Eating Syndrome
Avoidant Restrictive Food Intake Disorder (ARFID) DSM-5 Criteria (New)

1. Eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

   Significant weight loss (or failure to achieve expected weight gain), nutritional deficiency, dependence on enteral feeding or oral nutritional supplements, marked interference with psychosocial functioning.

2. Not better explained by lack of available food, culturally sanctioned practice, not exclusively during anorexia or bulimia nervosa, no evidence of body image distortion or a medical reason

### Lifetime Co-morbidity of Eating Disorders with Other Core Disorders Among U.S. Adults

#### Data from National Comorbidity Survey - Replication (NCS-R)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Anorexia Nervosa (%)</th>
<th>Bulimia Nervosa (%)</th>
<th>Binge-Eating Disorder (%)</th>
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<tbody>
<tr>
<td>Any Anxiety Disorder</td>
<td>47.9</td>
<td>80.6</td>
<td>65.1</td>
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<tr>
<td>Any Mood Disorder</td>
<td>42.1</td>
<td>70.7</td>
<td>46.4</td>
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<tr>
<td>Any Impulse Control Disorder</td>
<td>30.8</td>
<td>63.8</td>
<td>43.3</td>
</tr>
<tr>
<td>Any Substance Use Disorder</td>
<td>27.0</td>
<td>36.8</td>
<td>23.3</td>
</tr>
<tr>
<td>Any Disorder</td>
<td>56.2</td>
<td>94.5</td>
<td>78.9</td>
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# Lifetime Treatment of Eating Disorders Among U.S. Adults

Data from National Comorbidity Survey - Replication (NCS-R)\(^1\)

<table>
<thead>
<tr>
<th></th>
<th>Anorexia Nervosa (%)</th>
<th>Bulimia Nervosa (%)</th>
<th>Binge-Eating Disorder (%)</th>
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<tbody>
<tr>
<td>Total</td>
<td>33.8</td>
<td>43.2</td>
<td>43.6</td>
</tr>
<tr>
<td>Female</td>
<td>29.8</td>
<td>47.0</td>
<td>50.8</td>
</tr>
<tr>
<td>Male</td>
<td>50.2</td>
<td>29.1</td>
<td>28.9</td>
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Case Vignettes
A 17-year-old boy is hospitalized due to extreme weight loss over two years, and now has a BMI of 14. He refuses to eat the food served by the facility, stating that it has not been certified “farm fresh and organic, with absolutely no pesticides.”

He also refuses to eat any processed carbohydrates, stating that “sugars disrupt the body's insulin production,” or fats, because “they raise the body's cholesterol, which leads to heart attacks.”

However, he states that he eats “an abundance of locally grown green beans all day.”

Despite the weight loss, he insists that he is healthy due to the “purity” of the foods he eats.

**What is the most likely diagnosis?**
1. Anorexia Nervosa
2. Bulimia Nervosa
3. OSFED Anorexia Nervosa Type
4. Avoidant Restrictive Food Intake Disorder
A 17-year-old boy is concerned because of his eating habits, which he knows are unhealthy.

For the past several months, he has gone by himself to the local Chinese buffet restaurant every week, where he eats as much and as quickly as he can for more than an hour, until he feels so full he can barely move.

Once he gets home, he feels disgusted with himself, vomits up his meal, then promises himself that he will not repeat the cycle the next week.

In what weight category is this patient most likely?
1. Underweight
2. Overweight
3. Normal weight
4. High normal weight
# AED REPORT 2016 | 3RD EDITION
## EATING DISORDERS: A GUIDE TO MEDICAL CARE

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APPENDIX 1: An example of a validated screening tool for eating disorders—The SCOFF.* Other screening tools are available.

S  Do you make yourself Sick because you feel uncomfortably full?
C  Do you worry you have lost Control over how much you eat?
O  Have you recently lost more than One stone (6.35 kg or 14 lb) in a three-month period?
F  Do you believe yourself to be Fat when others say you are too thin?
F  Would you say Food dominates your life?

*Two or more positive responses on the SCOFF indicates a possible ED and should prompt referral for further evaluation.
A 14-year-old girl presents to the emergency department after losing consciousness while jogging at school.

She states that she needs to be discharged immediately so that she can finish her run, and that she will not make the cheerleading varsity team if she does not lose 10 more pounds.

She is 5 feet 2 inches tall and weighs 74 pounds, with a BMI of 13.5.

**Vital signs are likely to show which of the following?**

1. Tachycardia and Hypertension
2. Bradycardia and Hypotension
3. Tachycardia and Hypotension
4. Bradycardia and Hypertension
Intervention
1. (Mental health) clinicians should screen all child and adolescent patients for eating disorders  

[Clinical Standard]

2. A positive screening should be followed by a comprehensive diagnostic evaluation, including laboratory tests and imaging studies as indicated  

[Clinical Standard]

3. Severe acute physical signs and medical complications need to be treated  

[Clinical Standard]
4. Psychiatric hospitalization, day programs, partial hospitalization programs, and residential programs for eating disorders in children and adolescents should be considered only when outpatient interventions have been unsuccessful or are unavailable

[Clinical Guideline]

5. Outpatient psychosocial interventions are the initial treatment of choice for children and adolescents with eating disorders

[Clinical Standard]
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<th>Eating Disorder Outpatient Therapies</th>
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<tr>
<td>Family-based Treatment</td>
<td>Family therapy supports parental management of eating and related behavior until adolescent demonstrates improvement</td>
<td>Useful for most cases of short-duration AN and BN in young patients</td>
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<tr>
<td>Adolescent-focused therapy</td>
<td>Individual therapy targets autonomy and self-efficacy in the context of adolescent development</td>
<td>Useful for adolescents with AN when FBT is not feasible</td>
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<tr>
<td>Cognitive-behavioral therapy</td>
<td>Individually focused therapy targets adolescent management of behaviors and distorted cognitions associated with AN and BN</td>
<td>Adults, Adolescent version of CBT may be appropriate for use with BN</td>
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<tr>
<td>Interpersonal psychotherapy</td>
<td>IPT focuses on problematic interpersonal relationships that trigger or maintain eating disorder symptoms</td>
<td>Useful for cases of BN and BED an alternative to CBT</td>
</tr>
</tbody>
</table>
6. Treatment of eating disorders in youth usually involves a multidisciplinary team that is developmentally aware, sensitive, and skilled in the care of children and adolescents with eating disorders [Clinical Standard]

7. The use of medications, including complementary and alternative medications, should be reserved for comorbid conditions and refractory cases [Clinical Guideline]
FDA Approved Medications for Eating Disorders

Anorexia nervosa: None

Bulimia nervosa: Fluoxetine, high dose (~60 mg), quickly up-titrated

Binge eating disorder: Lisdexamfetamine


A 16-year-old girl presents to the outpatient clinic due to concerns of her parents about her weight. She states that, until a year ago, she was “chunky,” at 5 feet 3 inches tall and weighing 120 pounds (BMI 21.3).

She is now 5 feet 4 inches tall and weighs 102 pounds (BMI 17.5) and plans to lose “just five more pounds to be on the safe side.”

Despite both threats and positive reinforcement attempts by her parents, she continues to restrict her intake and exercise constantly.

What treatment is most appropriate for this patient?

1. Outpatient Treatment
2. Day Hospital Treatment
3. Residential Treatment
4. Inpatient Treatment
- Eleven-year-old Helen is in a gifted and talented school, is below the 10th %ile age adjusted body mass index, BMI (kg / m²). She was at the 25th percentile at age 9.
- A therapist had been treating Helen for anxiety.
- Helen’s eating difficulties started at age 9, when she began refusing to eat and reporting a fear that she would vomit.
- She had never entirely, reported
- She had never entirely, reported
- She had never entirely, reported
- She had never entirely, reported
- For the prior 2 years, Helen had eaten only very small amounts of food over very long durations of time.
- For the prior 2 years, Helen had eaten only very small amounts of food over very long durations of time.
- Both parents reported a similar mealtime pattern: Helen would agree to sit at the table but then spent her time rearranging food on her plate, cutting food items into small pieces, and crying if urged to eat another bite.
- Helen denied any concerns about her appearance and only became aware of her low weight after her most recent visit to the pediatrician. When educated about the dangers of low body weight, Helen became tearful and expressed a clear desire to gain weight.

What statement about medication is likely correct?
1. Appetite stimulating medication will improve the condition
2. Medication has no role for this patient
3. Medication may be best used for comorbid conditions
Working With the Family
Family Based Therapy (FBT)

The “Maudsley approach”, an intensive outpatient treatment where parents play an active and positive role to help

1. Restore their child's weight to normal levels expected given their adolescent's age and height
2. Hand the control over eating back to the adolescent
3. Encourage normal adolescent development through an in-depth discussion of these crucial developmental issues as they pertain to their child.
Intensive Family Treatment (IFT)

1. One-week intensive to provide parents or other family members with an understanding and tools necessary to successfully interact and manage their loved one with an eating disorder at home.

2. We teach patients how to understand the symptoms that they are having and develop more effective coping strategies.

3. Treatment includes
   - Psychoeducation
   - Coping skills training
   - Parent training
   - Meal coaching
   - Novel neurobiological skills based on brain imaging research