

# **Psychopathology for Clinical Social Work Practice**

Feeding and eating Disorders

# Feeding and Eating Disorders

- In DSM-5, eating disorders and feeding disorders have been combined in a new chapter, feeding and eating disorders
- In DSM-IV, feeding disorders were known as feeding disorder of infancy or early childhood
- Feeding and eating disorders are characterized by recurrent disturbances in a person's eating behaviors, which results in significant physical and/or psychosocial impairment. (APA, 2013)

# **Feeding and Eating Disorders in DSM-5**

**1) Pica**

**2) Rumination Disorder**

**3) Avoidant/Restrictive Food Intake Disorder**

**4) Anorexia Nervosa**

**5) Bulimia Nervosa**

**6) Binge Eating Disorder**

**7) Other Specified Feeding or Eating Disorder**

**8) Unspecified Feeding or Eating Disorder**

# Feeding Disorders Prevalence

- 1 of every 4 children are reported to have some sort of feeding disorder
- Children with developmental disabilities have higher chance of having any types of feeding disorders.
- A small number of children have symptoms severe enough to need clinical treatment

# 1) Pica in DSM-5

- A. Repeated eating of nonnutritive substances for at least 1 month.
- B. The eating of nonnutritive substances is inappropriate to the developmental level.
- C. The eating behavior is not part of a culturally sanctioned practice.
- D. If the eating behavior occurs exclusively during the course of another mental disorder clinical attention is needed.

## Treatment:

- A. physical exam- blood tests, checking for anemia, toxin and blockages in the intestinal tract, etc.
- B. Behavior modification- training in distinguishing edible and non-edible foods

- Mrs H, a 35 year old female, Hindu by religion, married with an eight month old male baby, studied till degree, currently not working, belonging to middle socio-economic status family, with no family history and no past history of any psychiatric illness or neurodevelopmental delay. She presented to the psychiatry outpatient department with complaints of **consuming paper and cardboard whenever** she was alone from the past 2 months. The onset of her symptomatology was eight months into her post-partum period, was of an insidious onset and progressive nature. Every time she unpacked toys for her child, she would **repeatedly smell the cardboard boxes and had an intense liking for the same**. When alone at home, she felt like tasting those **cardboard papers and ate a few pieces**. There were no negative consequences the first time she ate a few pieces which further reinforced her interest. Gradually over the course of a week, she also **started chewing on the ends of pencils and ice-cream sticks**. On certain days she would end up **consuming two to three A4 size sheets bit by bit**. The fear of being caught in the act produced significant distress but when alone it would facilitate aggravated consumption. On further detailed evaluation she reported of **low mood consistently for the past 2 months** because she felt constrained to her home as she was unable to go for work like she used to previously. She had **decreased interest in carrying out daily routine work**. She reported that she would feel very tired throughout the day and doing household work was becoming laborious. Previously she used to enjoy going out with her friends and family but since the past two months she always **preferred to be alone**. She did not feel that it was irrational to consume the paper items and did not find it distressful. She also revealed the truth that **this habit of eating cardboard and paper gave her a sense of relaxation and helped her forget her worries**. Her physical examination was normal and on MSE she was well kempt and groomed, rapport was established with ease. Her mood was **subjectively sad and objectively depressed**. There was no thought or perceptual disturbances. Her cognitive functions were found to be normal. Hamilton Rating Scale for Depression was applied and **her score was found to be 24**. Complete blood count revealed Hemoglobin of 10.8 mg/dl and other blood parameters were within normal range. Urine routine examination, X-ray abdomen, Ultrasound abdomen was found to be normal.

## **2) Rumination Disorder in DSM-5**

- A. Repeated regurgitation and rechewing of food for at least 1 month
- B. The repeated regurgitation is not due to an associated gastrointestinal or other general medical condition
- C. The behavior does not occur exclusively in the course of Anorexia Nervosa or Bulimia Nervosa during the course
- D. Clinical attention is needed if symptoms occur in the presence of another medical condition such as intellectual developmental disorder.

Treatment- Breathing exercise and habit reversal

# 3) Avoidant/Restrictive Food Intake Disorder (ARFID) in DSM-5

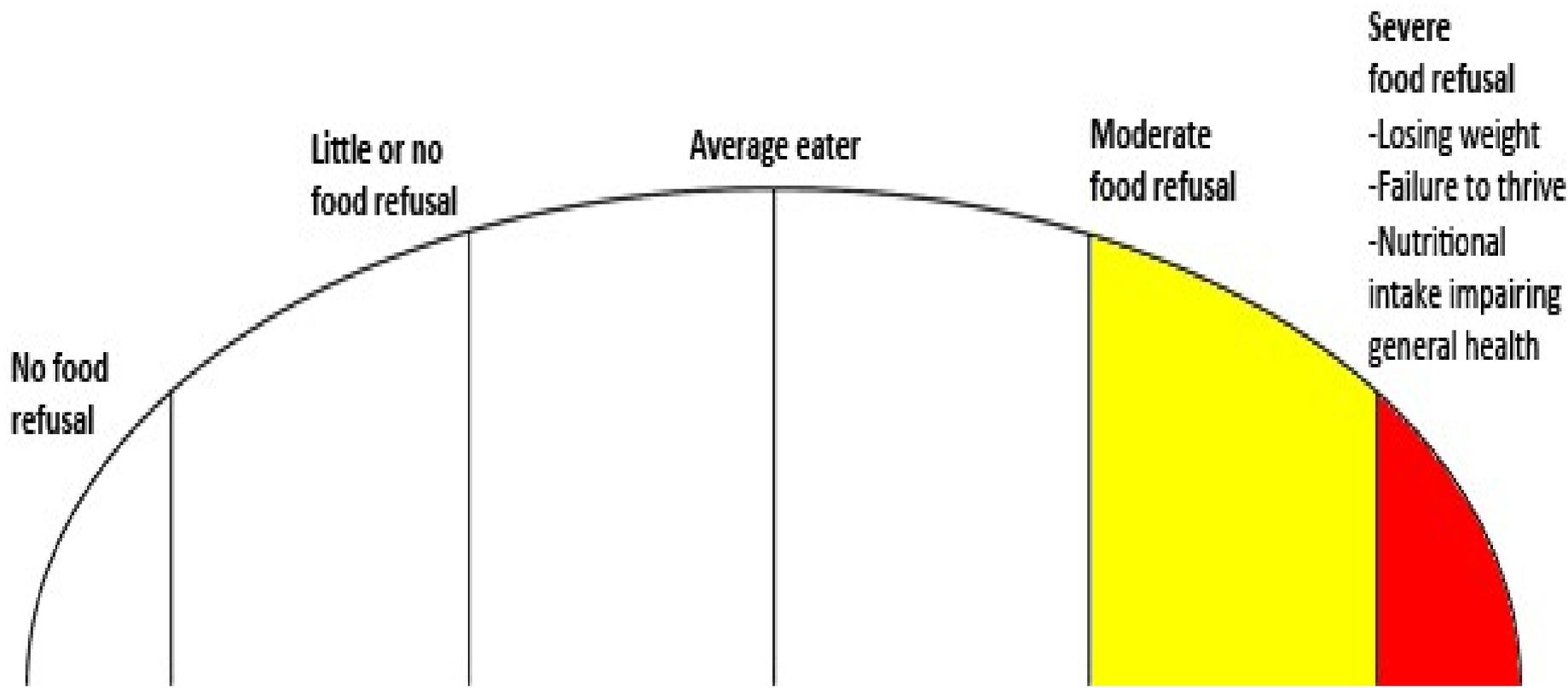
- New diagnosis in DSM-5, previously referred to “Selective Eating disorder”
- A. An eating or feeding disturbance as manifested by repeated failure to obtain appropriate nutritional and/or energy needs associated with at least one of the following:
  - Significant weight loss
  - Significant nutritional deficiency
  - Dependence on enteral feeding or oral nutritional supplements
  - Marked interference with psychosocial functioning
- B. The eating disturbance is not associated with lack of food, culturally sanctioned practice, other eating disorders and medical condition

# TEENAGER WENT BLIND AFTER ONLY EATING FRIES, CHIPS, WHITE BREAD, SAUSAGES AND HAM SINCE ELEMENTARY SCHOOL

BY **KASHMIRA GANDER** ON 9/2/19 AT 5:00 PM EDT



<https://www.newsweek.com/teenager-blind-tries-chips-white-bread-sausages-ham-elementary-school-1456937>



Source: <http://pediatricfeeding.com/feeding-disorders/>

# Risk factors of ARFID

- Biological, psychological and sociocultural factors
- Autism spectrum Disorder, ADHD and intellectual disabilities
- Picky eating habit
- Can comorbid with anxiety disorder and at high risk for other psychiatric disorders

# Treatments for adults with ARFID

- Treatment goal- correcting nutritional deficiencies, impaired psychosocial functioning, inadequate growth, and/or weight loss.
  - CBT: addressing negative thoughts
  - Exposure therapy: Working on a hierarch of fear foods from least fearful to most anxiety provoking; mental visualization; writing and verbal talking through steps to exposure; life practice sessions
  - DBT: Mindfulness within the moment, distress tolerance skills
  - Group therapy and group meals
  - Residential therapy

# Treatment for children with ARFID

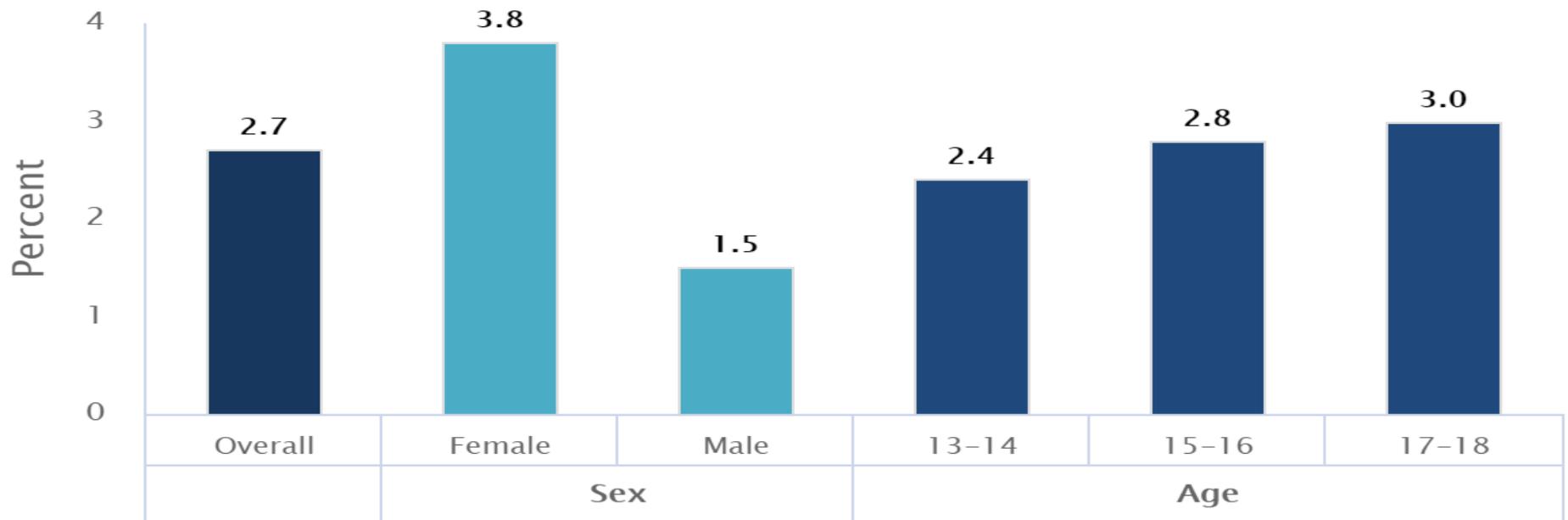
- Goal- developing an appropriate set of behaviors that yield a proper mealtime experience
  - Food refusal treatment- Identifying types of food-refusal related conditions
    - 1) Texture
    - 2) Complete food refusal
    - 3) food selectivity,
    - and 4) low-volume acceptance
  - Behavioral modification
    - Identify less and more preferred food, and amount of food children eat
    - Using preferred food as reinforces for consumption of less preferred foods. However, restricting accessing to preferred foods for only a certain length of time prior to meals
    - Simultaneously presenting or blending more preferred foods or drinks with less preferred foods
- [Bachmeyer](#)  
(2009)

# Prevalence of Eating Disorders

Onset of eating disorders often in adolescence and presence in the adult years as well

## Lifetime Prevalence of Eating Disorders Among U.S. Adolescents (2001–2004)

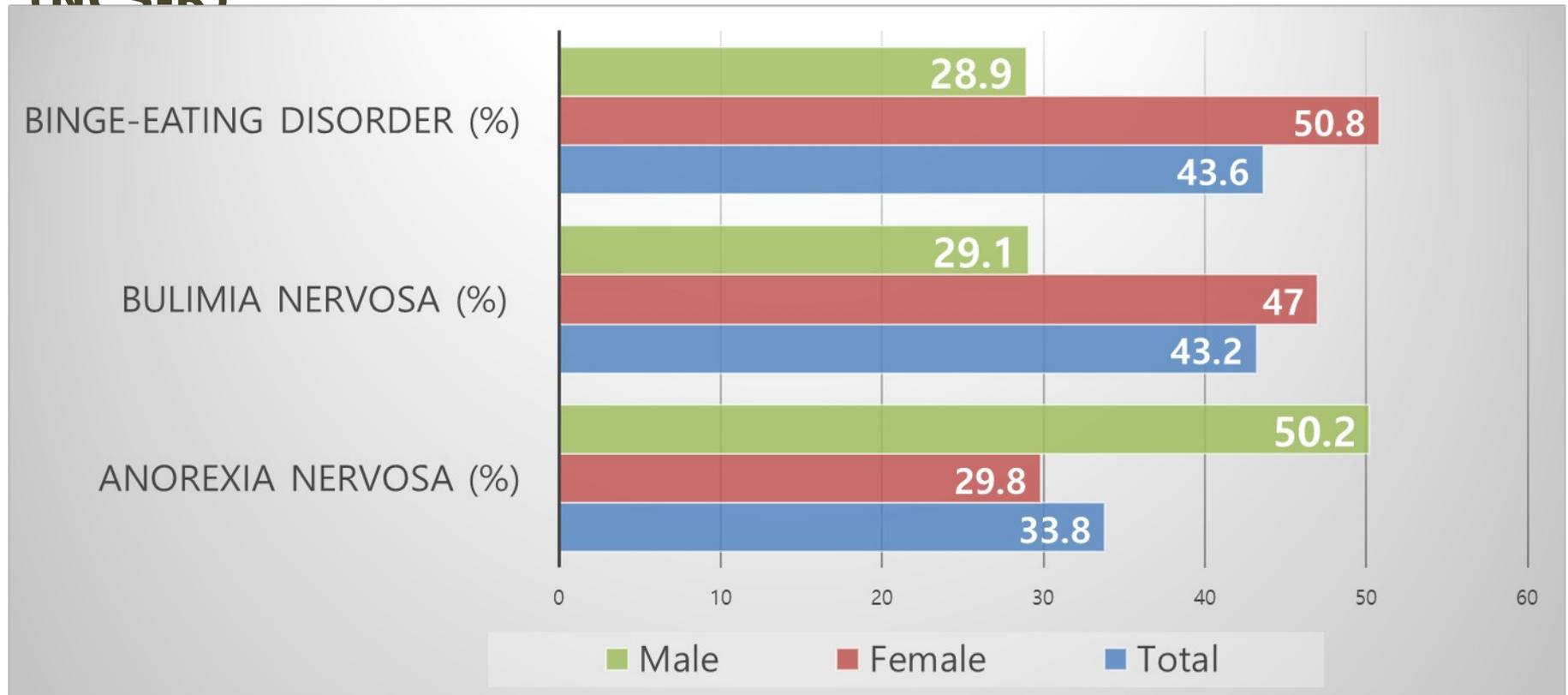
Data from National Comorbidity Survey Adolescent Supplement (NCS-A)



NIMH (n.d.).

# Prevalence of Eating Disorders

**Lifetime Treatment of Eating Disorders Among U.S. Adults Data from National Comorbidity Survey Replication (NCS-R)**



NIMH (n.d.).

# Comorbidity of Eating Disorders

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

Data from National Comorbidity Survey - Replication (NCS-R)<sup>1</sup>

	Anorexia Nervosa (%)	Bulimia Nervosa (%)	Binge-Eating Disorder (%)
Any Anxiety Disorder	47.9	80.6	65.1
Any Mood Disorder	42.1	70.7	46.4
Any Impulse Control Disorder	30.8	63.8	43.3
Any Substance Use Disorder	27.0	36.8	23.3
Any Disorder	56.2	94.5	78.9

- Eating disorders are associated with ODD, CD, ADHD and intermittent explosive disorder <sup>NIMH (n.d.).</sup>
- Bingeing and purging are associated with ADHD
- 31% of women with bipolar disorder have an eating disorder
- Bulimia is associated with cluster B (borderline) and C (avoidant) PD, while cluster c (avoidant and obsessive-compulsive) PD are associated with anorexia

Corcoran & Walsh (2010).

# 4) Anorexia Nervosa in DSM-5

- A. Persistent restriction of energy intake causing significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health)
- B. Either an intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain (even though significantly low weight).
- C. Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

## **Specify whether:**

Restricting type

Binge-eating/purging type

## **Specify if:**

In partial remission

In full remission

## **Specify** current severity with BMI

Mild: BMI > 17 kg/m<sup>2</sup>

Moderate: BMI 16-16.99 kg/m<sup>2</sup>

Severe: BMI 15-15.99 kg/m<sup>2</sup>

Extreme: BMI < 15 kg/m<sup>2</sup>

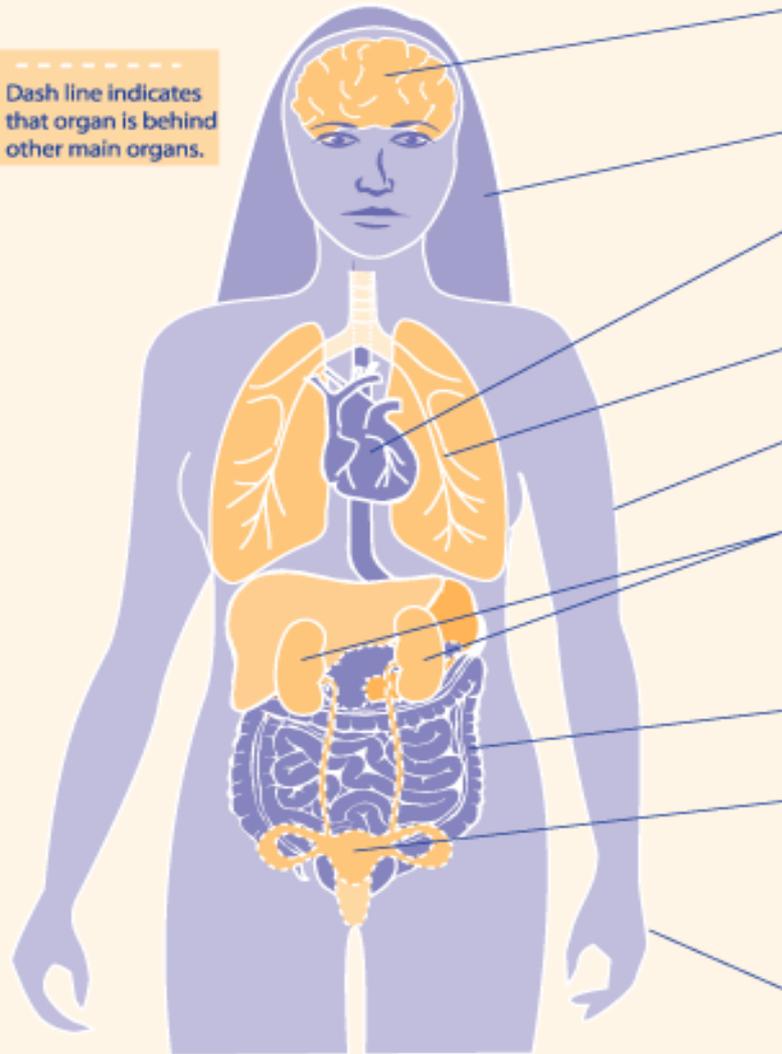
# 5) Bulimia Nervosa in DSM-5

- A. Recurrent episodes of following binge eating.
  - 1. Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
  - 2. A sense of lack of control over eating during the episode
- B. Recurrent inappropriate compensatory behavior not to gain weight (i.e., self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise).
- C. The binge eating and inappropriate compensatory behaviors **both** occur, on average, at least once a week for three months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify current severity: Mild (1-3 episodes per week), Moderate (4-7 episodes per week), Severe (8-13 episodes per week), Extreme (more than 14 episode)

## Anorexia affects your whole body

Dash line indicates that organ is behind other main organs.



### **Brain and Nerves**

can't think right, fear of gaining weight, sad, moody, irritable, bad memory, fainting, changes in brain chemistry

### **Hair**

hair thins and gets brittle

### **Heart**

low blood pressure, slow heart rate, fluttering of the heart (palpitations), heart failure

### **Blood**

anemia and other blood problems

### **Muscles and Joints**

weak muscles, swollen joints, fractures, osteoporosis

### **Kidneys**

kidney stones, kidney failure

### **Body Fluids**

low potassium, magnesium, and sodium

### **Intestines**

constipation, bloating

### **Hormones**

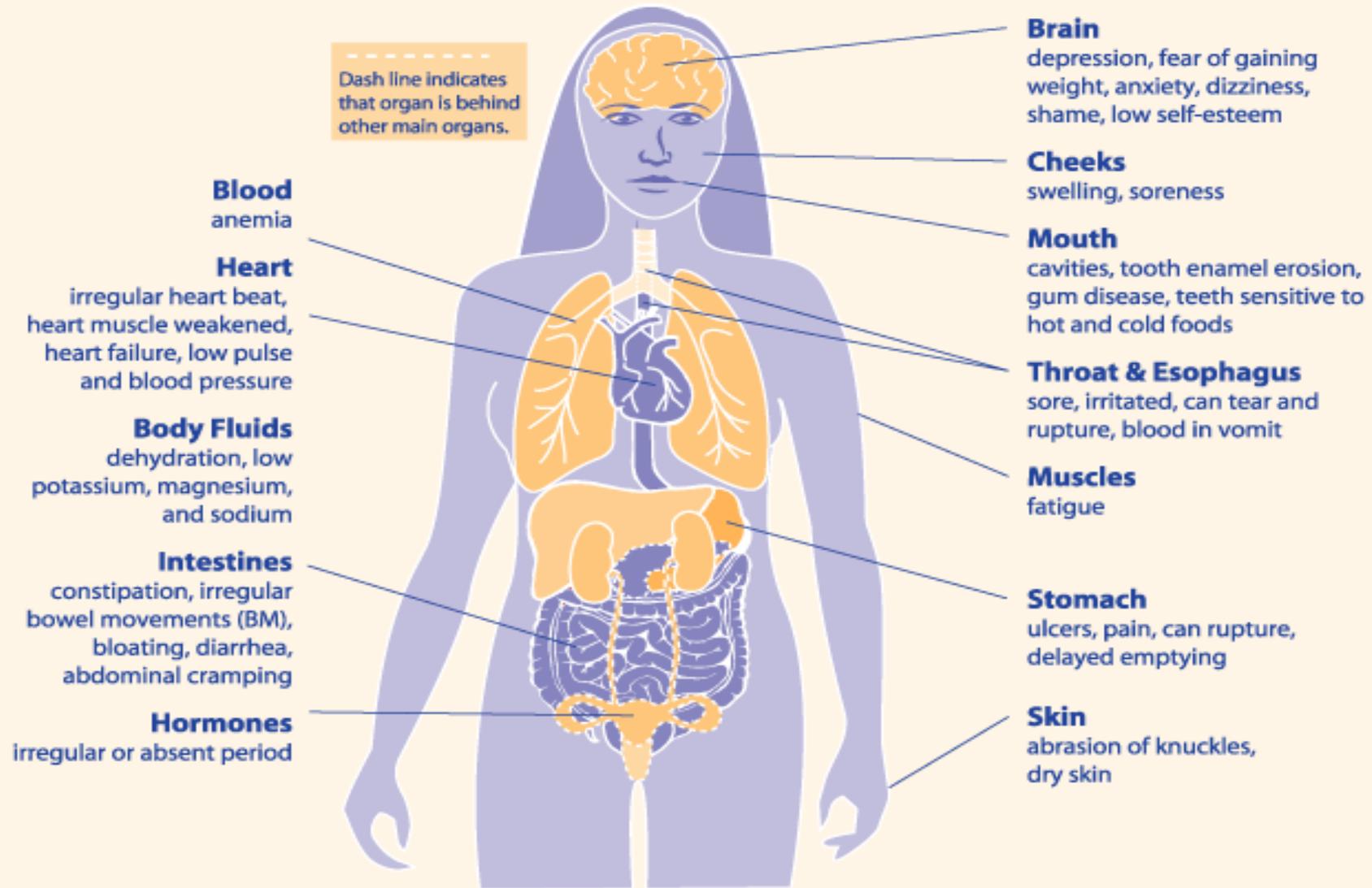
periods stop, bone loss, problems growing, trouble getting pregnant. If pregnant, higher risk for miscarriage, having a C-section, baby with low birthweight, and post partum depression.

### **Skin**

bruise easily, dry skin, growth of fine hair all over body, get cold easily, yellow skin, nails get brittle

## How bulimia affects your body

Dash line indicates that organ is behind other main organs.



# 5) Binge Eating Disorder in DSM-5

- A. Recurrent two binge eating episodes below at least once a week for 3 months.
  - 1. Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
  - 2. A sense of lack of control over eating during the episode
- B. The binge eating episodes are associated with three or more of the following:
  - 1. eating much more rapidly than normal
  - 2. eating until feeling uncomfortably full
  - 3. eating large amounts of food when not feeling physically hungry
  - 4. eating alone because of feeling embarrassed by how much one is eating
  - 5. feeling disgusted with oneself, depressed or very guilty afterward

**Specify** severity as bulimia

## **6) Other Specified Feeding or Eating Disorders**

1. Atypical anorexia nervosa
2. Bulimia nervosa
3. Binge-eating disorder
4. Purging disorder
5. Night eating syndrome

# Risk Factors

## 1) Biological

- Heritability
- Preterm and obstetrical complications
- Early pubertal maturation
- Adolescent developmental stage
- Obesity

## 2) Psychological

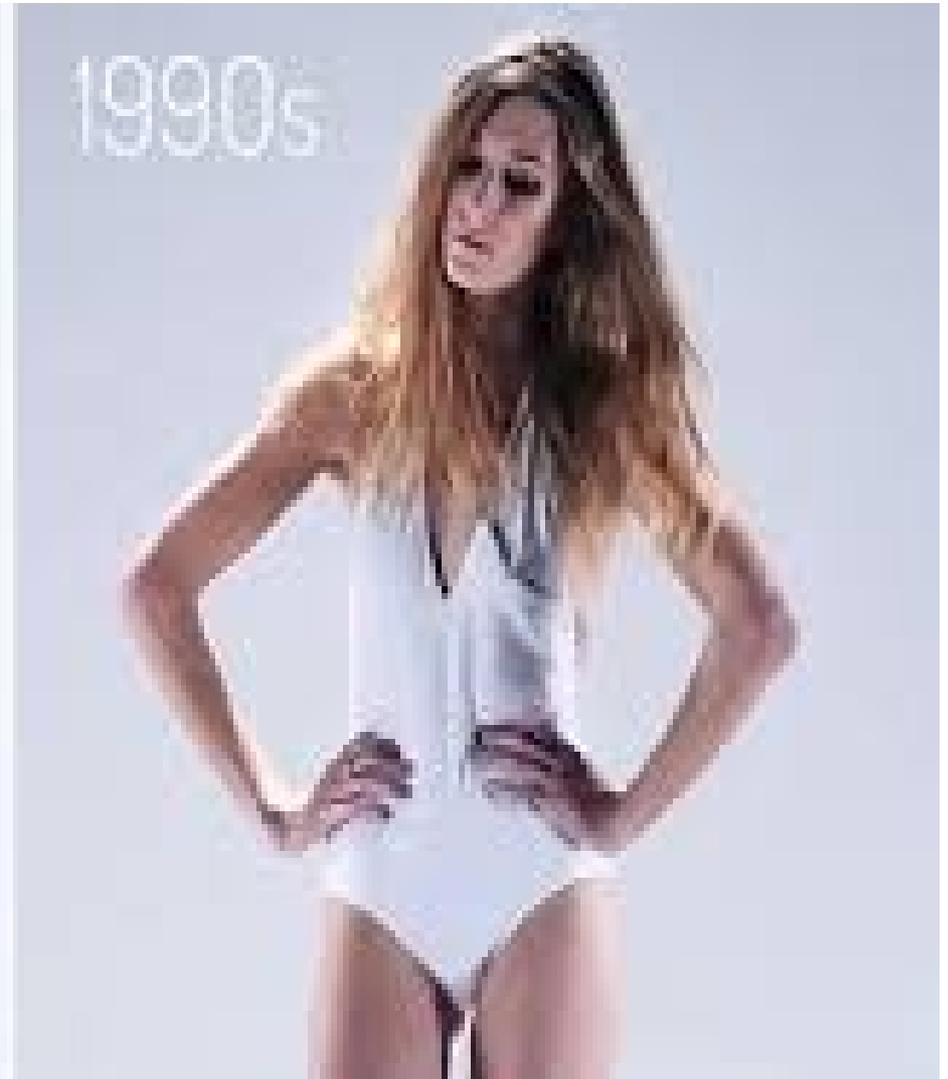
- Comorbid psychiatric disorders (i.e., depression, anxiety)
- Traits such as perfectionism, obsessionality, excessive compliance, low self-esteem, negative affect/attitude
- Body dissatisfaction and distortion
- Poor social skills and isolation
- Low motivation

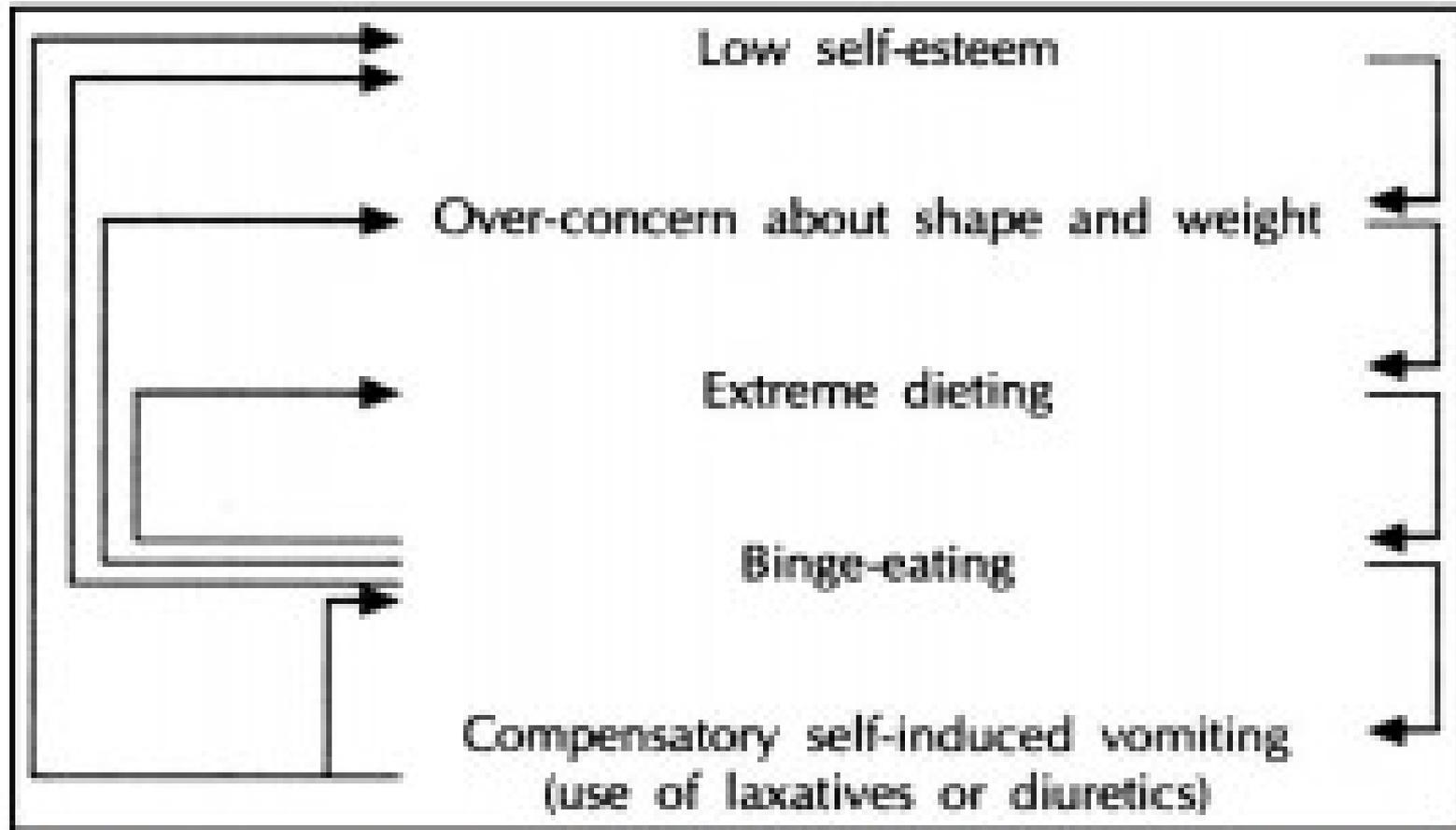
# Risk Factors

## 3) Social

- Family
- Interactional problems in the family
- Attachment problems
- Inadequate parenting
- Transmission of societal emphasis on weight and appearance
- Sexual abuse
- Social isolation, social anxiety

- Social Values- emphasis on thinness as female beauty





**Fig. 4.** The cognitive view of the maintenance of bulimia nervosa.

# Assessment

- A standard clinical interview
- Client self-monitoring of eating, bingeing, and purging behavior
- Questionnaire measures of eating disorders, body image, and other psychopathology (i.e., The eating attitude test, the eating disorders inventory-3, Eating disorders examination-Questionnaire version, Eating disorder diagnostic scale, etc.)
- A medical evaluation – a routine checkup, assessment of risk due to weight loss and amenorrhea, lab tests of electrolyte imbalances
- Assessment of comorbid disorder
- A developmental history

# Interventions for Anorexia

 Very good evidence  
 Good evidence  
 Promising  
 treatment

Medications- no psychotropic medications as the sole or primary treatment	Effectiveness
<b>SSRIs- antidepressant</b> ; effective when anxiety or depression is also present	

Interventions	Effectiveness
<b>Family-based therapy</b> More effective than individual therapy; helping parents unite and stand up to an externalized illness and refeed their adolescent	
<b>Motivational Interviewing</b> A client-centered, collaborative, but directive method is effective because people with anorexia are not motivated to change	
<b>CBT (schema therapy)</b> Changing dysfunctional core belief systems into functional schema	
<b>Psychoeducation for caregivers</b> Reducing caregiver distress and burden	

# Interventions for Bulimia

 Very good evidence treatment  Good evidence  Promising

**Medications- no psychotropic medications as the sole or primary treatment**

**Effectiveness**

**SSRIs- antidepressant**

Floxetine(Prozac) is rather effective



**Interventions**

**Effectiveness**

**Motivational Interviewing**

A client-centered, collaborative, but directive method is effective because people with bulimia are not motivated to change



**CBT (schema therapy)**

Changing dysfunctional core belief systems into functional schema



**Interpersonal therapy**

Developed for depression, but used for adolescents with BN; focus on interpersonal issues



**Internet Therapy**

Effective for some people with binge eating, not for purging behaviors



# Interventions for Binge Eating Disorder

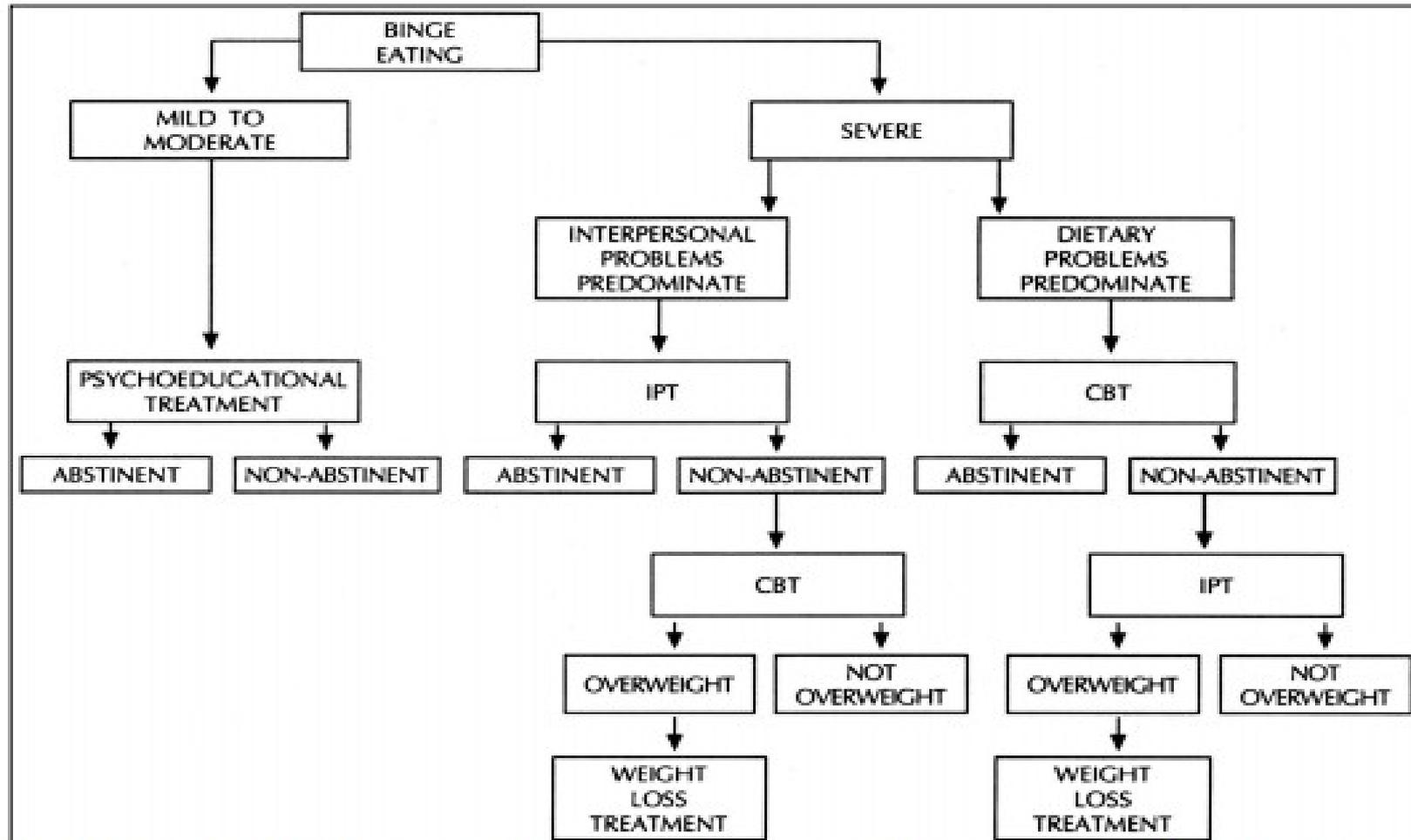


Fig. 3. A flow chart illustrating a hypothetical comprehensive model of the psychological treatment of binge eating.

Kim (1997)

## Eating Behavior record

Time	Foods that ate	Place	Binging	Purging	Purgative meds	Situation/ emotion/ thought
7:45	Apple 1 Orange 1	Kitchen				Feeling bad I thought I gain weight
3:10	Sandwich 3 Donut 1	Work	X			I bought too many sandwiches I should've not eaten those sandwiches
3:45	Donuts 3 Tea 1 Cake 1 Tea 1 Tea 1	Work		X		I can't stop eating. Help me.  Weigh-in 160 lbs. I want to cry. I should not eat today
8:20	Toast 2	Kitchen	X			
8:25	Toast 1 Coke 1	Kitchen	X			
8:40	Biscuit 1 dozen	Kitchen	X			I am pathetic
8:50	Biscuit 1 dozen Ice cream 1 Coke 1		X			I am full
9:05	Cereal 1	Kitchen	X		X	Weigh-in 162 lbs.

# Reference

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