

Advanced Clinical Assessment and Diagnosis

Feeding and eating Disorders

Feeding and Eating Disorders

- Since DSM-5 was published, 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

From
Parenting

Pica in Children

• Causes • Symptoms • Treatment



1) Pica in DSM-5-TR

- 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:

- 1) Physical exam- blood tests, checking for anemia, toxin and blockages in the intestinal tract, etc.
- 2) 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 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.

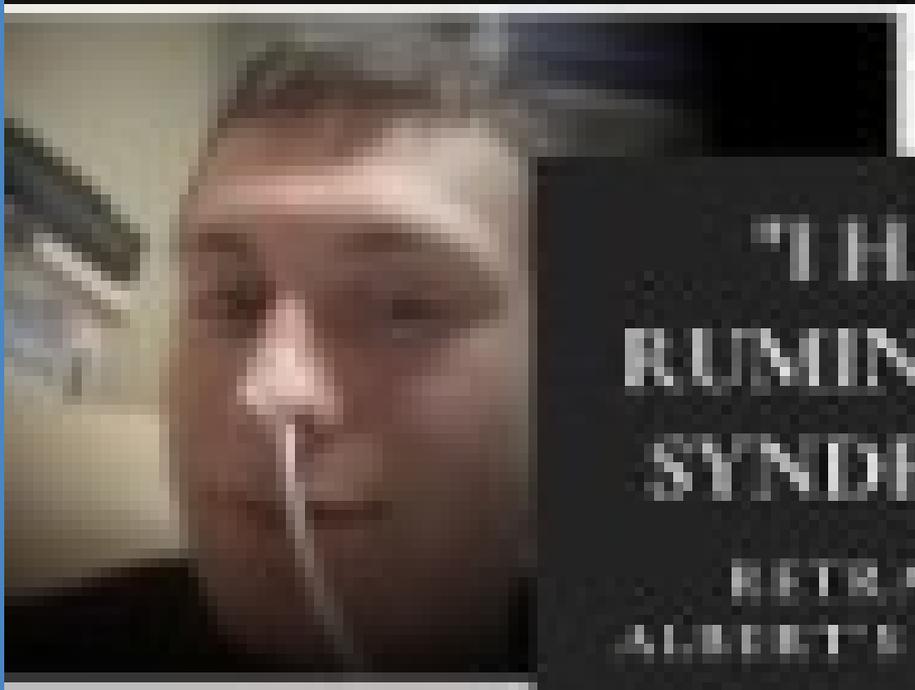
2) Rumination Disorder in DSM-5

- 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.

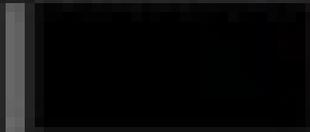
Specify if: In remission: After full criteria for rumination disorder were previously met, the criteria have not been met for a sustained period of time- Same for Pica and ARFID

Treatment- Diaphragmatic Breathing exercise

2) Rumination Disorder in DSM-5



"I HAVE
RUMINATION
SYNDROME."
RETRAINING
ALBERT'S STOMACH



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

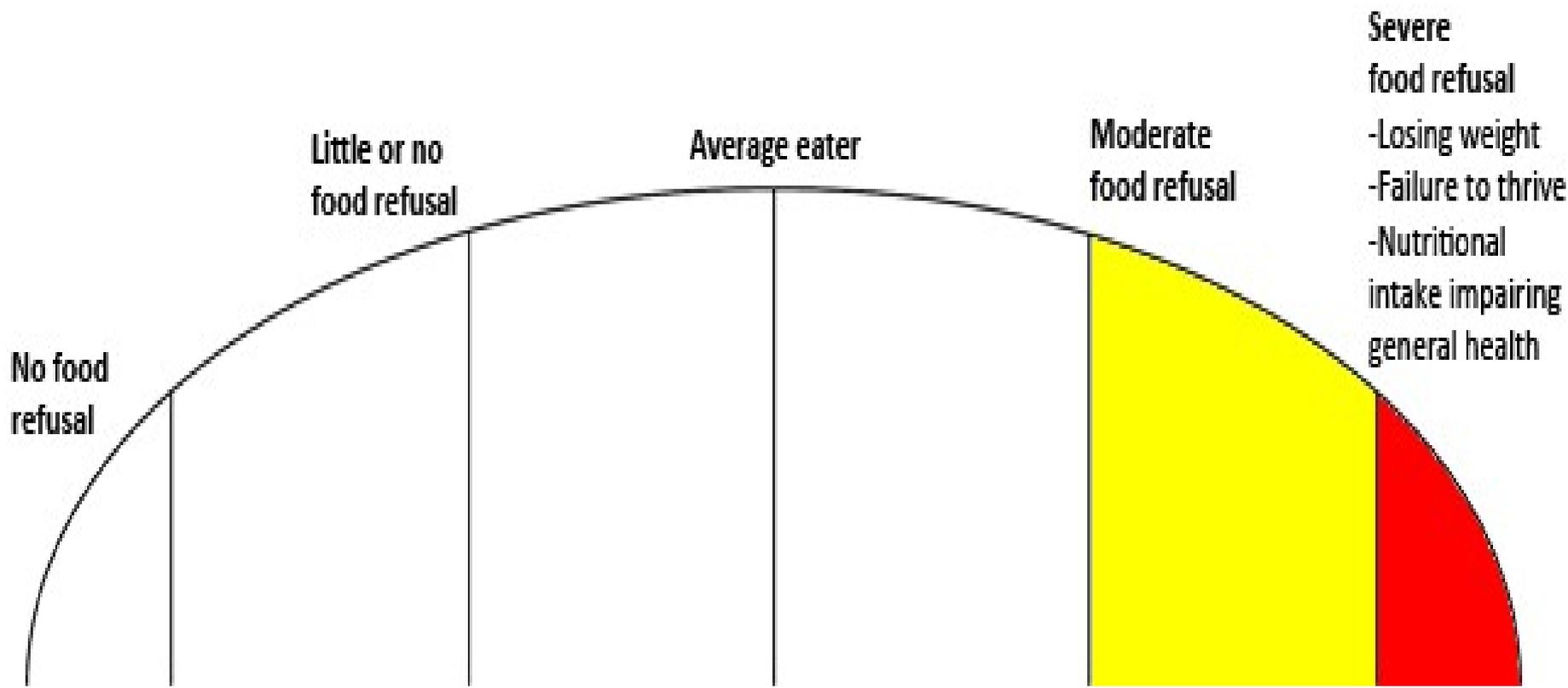
- New diagnosis since DSM-5, previously referred to “Feeding Disorder of Infancy or Early” for children under 6 years old
- A. An eating or feeding disturbance as manifested by repeated failure to obtain appropriate nutritional and/or energy needs associated with at least one of the following:
 - Significant 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/>

3) Avoidant/Restrictive Food Intake Disorder (ARFID) in



Risk factors of ARFID

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

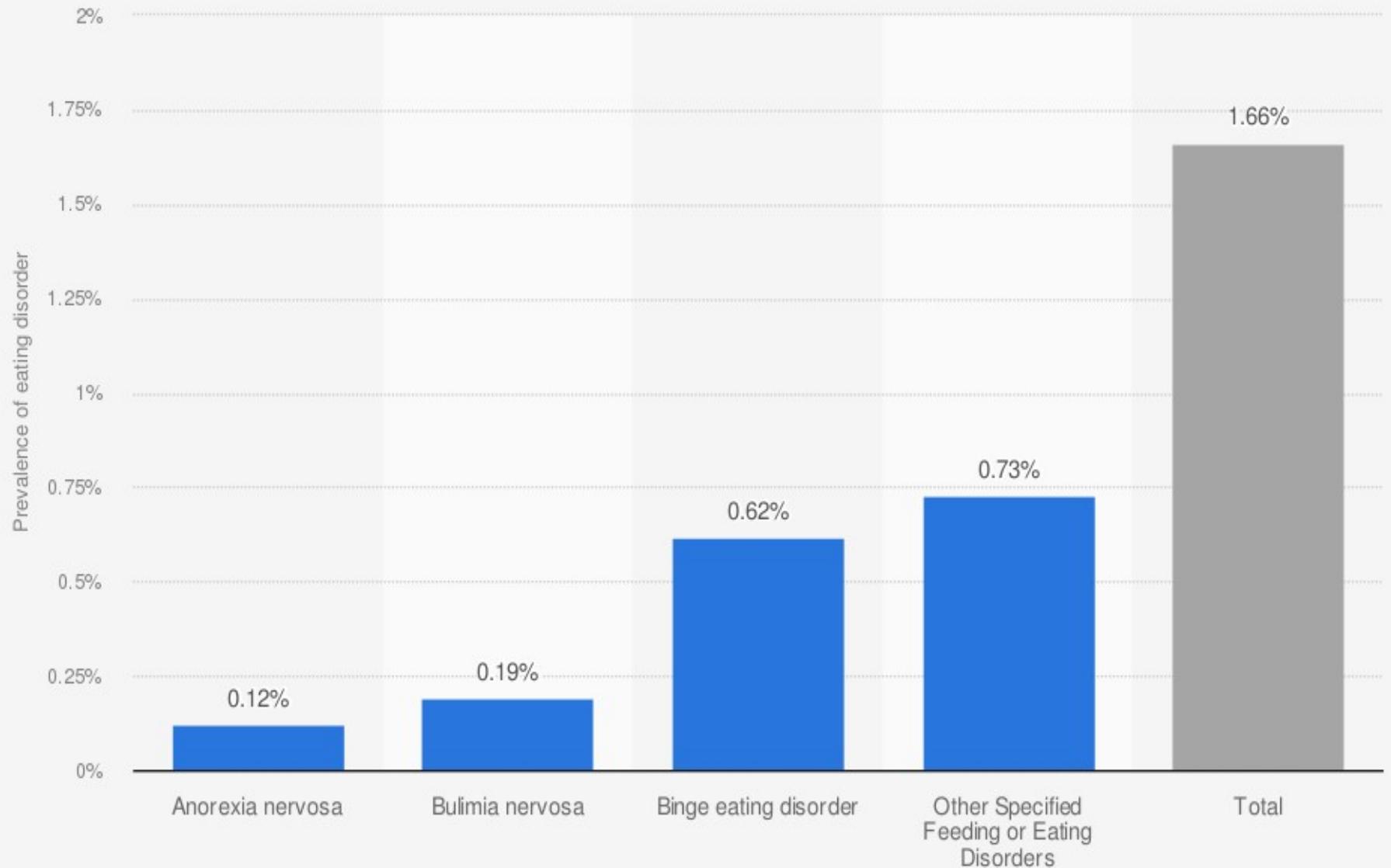
Treatments for adults with ARFID

- 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

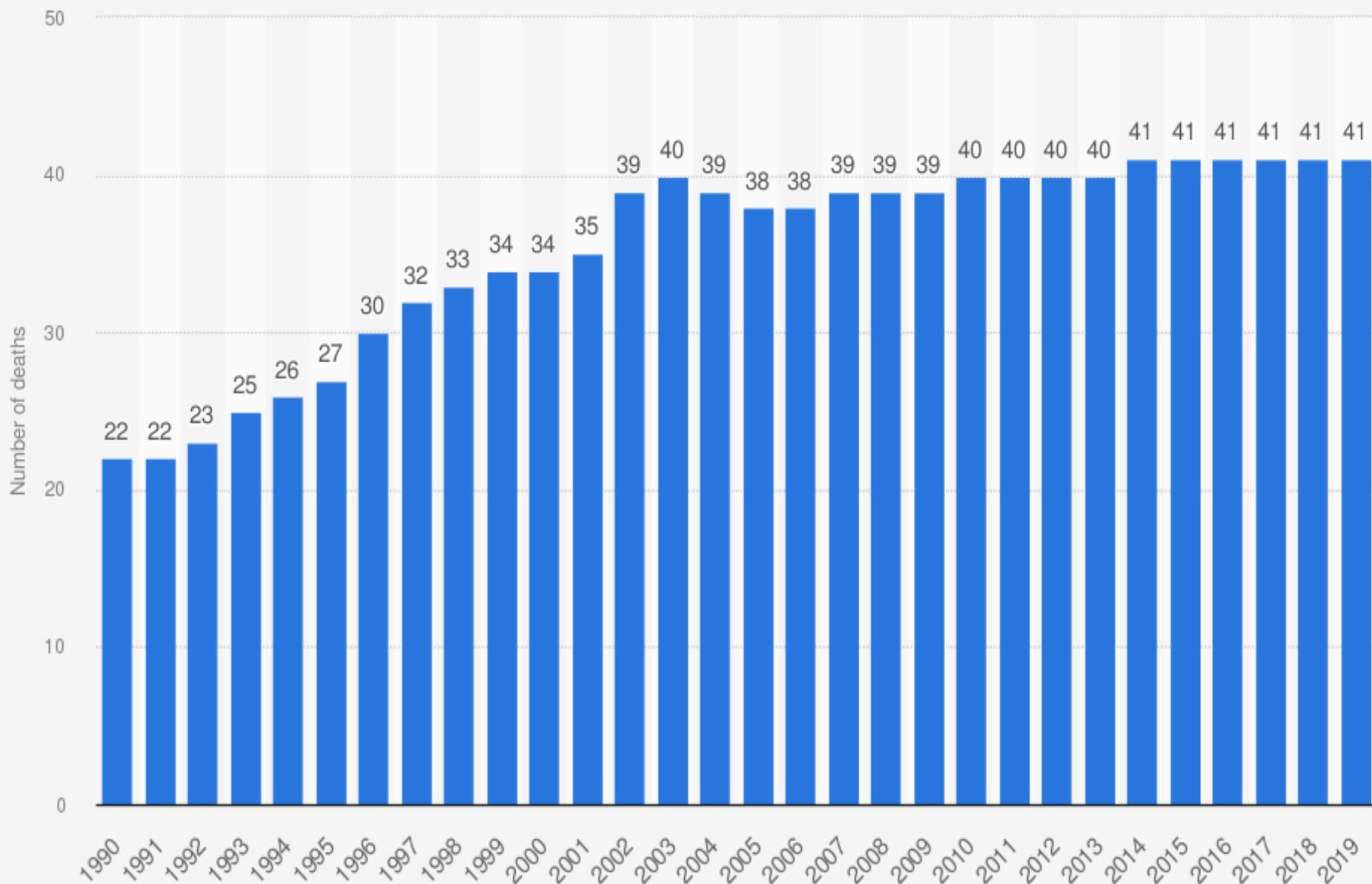
Treatment for children with ARFID

- 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
- (2009) [Bachmeyer](#)

Prevalence of eating disorders in the United States from 2018 to 2019, by condition

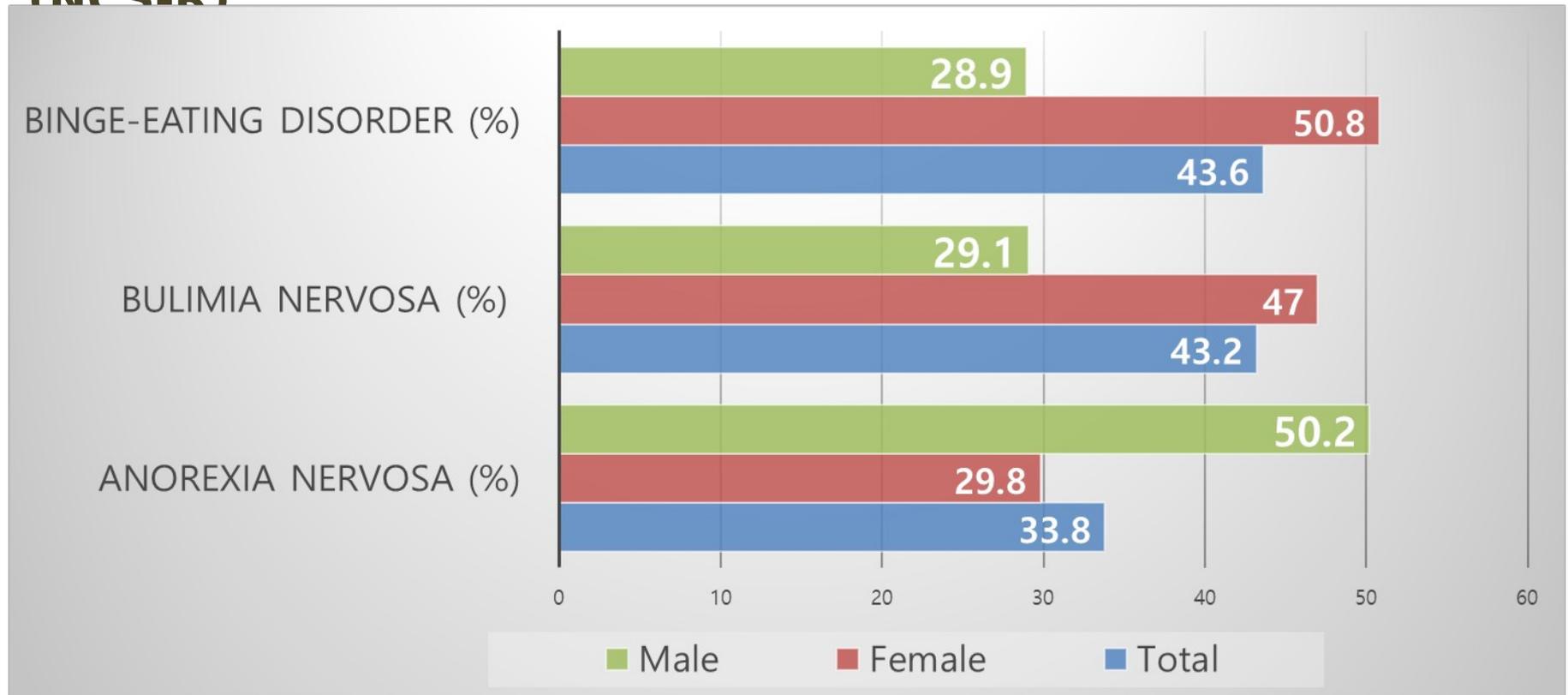


Number of direct deaths from eating disorders in the U.S. from 1990 to 2019



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)¹

	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 ^{NIMH (n.d.).}
- 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



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

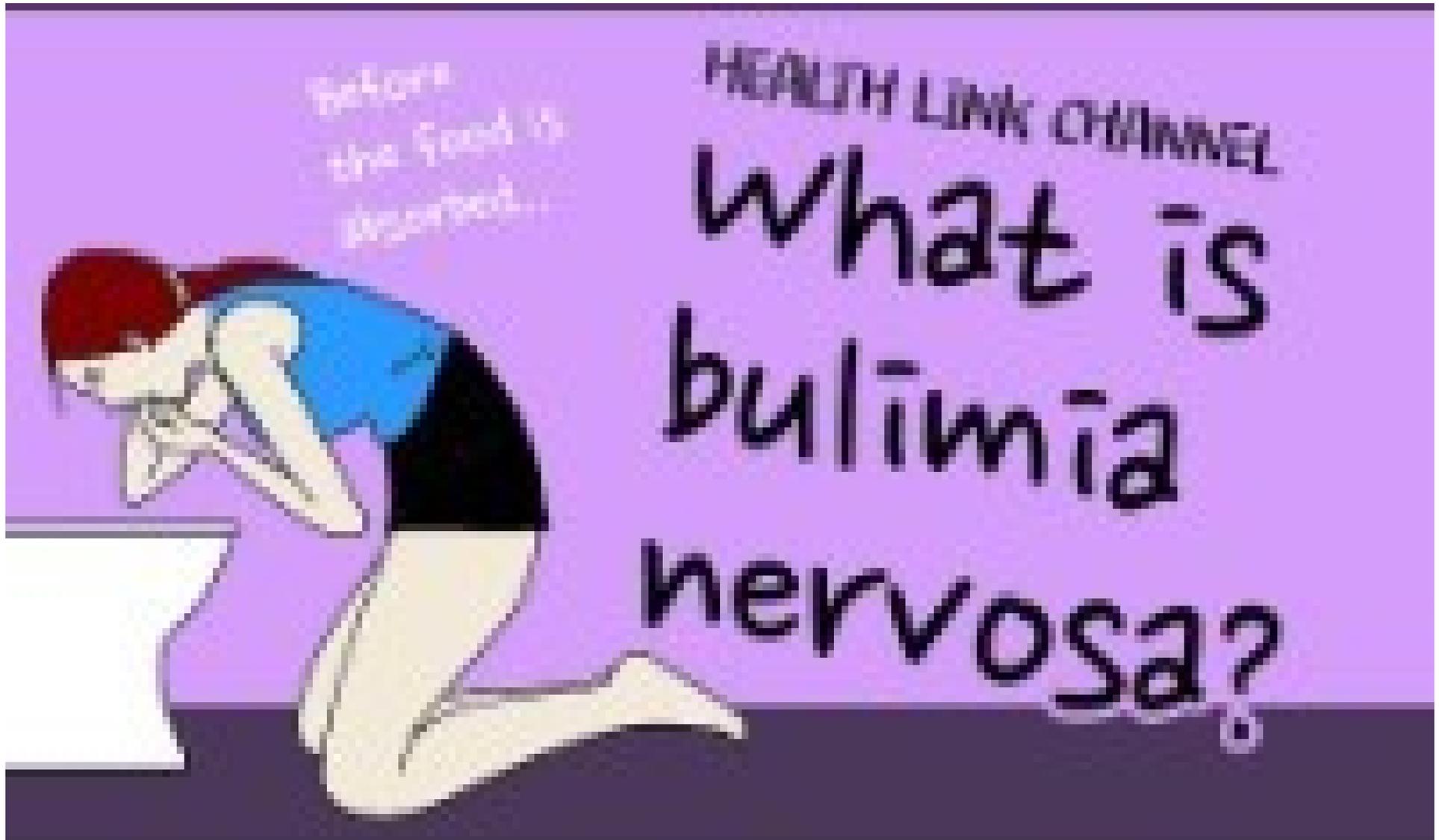
Mild: BMI > 17 kg/m²

Moderate: BMI 16-16.99 kg/m²

Severe: BMI 15-15.99 kg/m²

Extreme: BMI < 15 kg/m²

5) Bulimia Nervosa in DSM-5



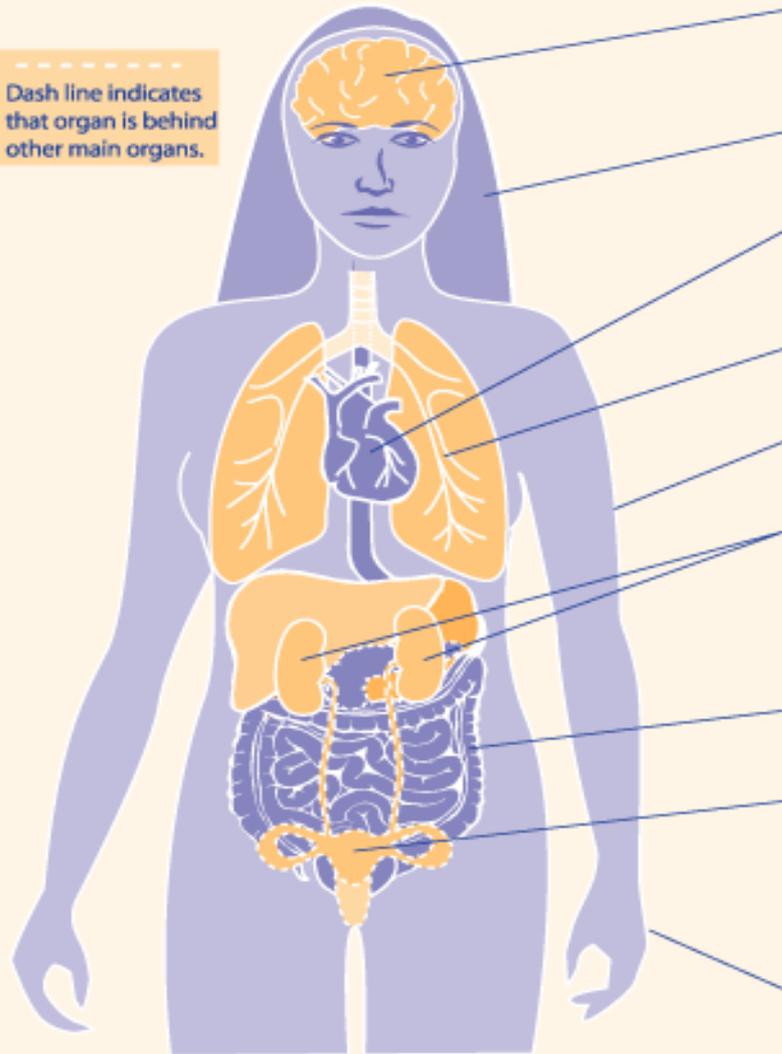
5) Bulimia Nervosa in DSM-5

- 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 3 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 inappropriate compensatory 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.

Brain

depression, fear of gaining weight, anxiety, dizziness, shame, low self-esteem

Cheeks

swelling, soreness

Mouth

cavities, tooth enamel erosion, gum disease, teeth sensitive to hot and cold foods

Throat & Esophagus

sore, irritated, can tear and rupture, blood in vomit

Muscles

fatigue

Stomach

ulcers, pain, can rupture, delayed emptying

Skin

abrasion of knuckles, dry skin

Blood

anemia

Heart

irregular heart beat, heart muscle weakened, heart failure, low pulse and blood pressure

Body Fluids

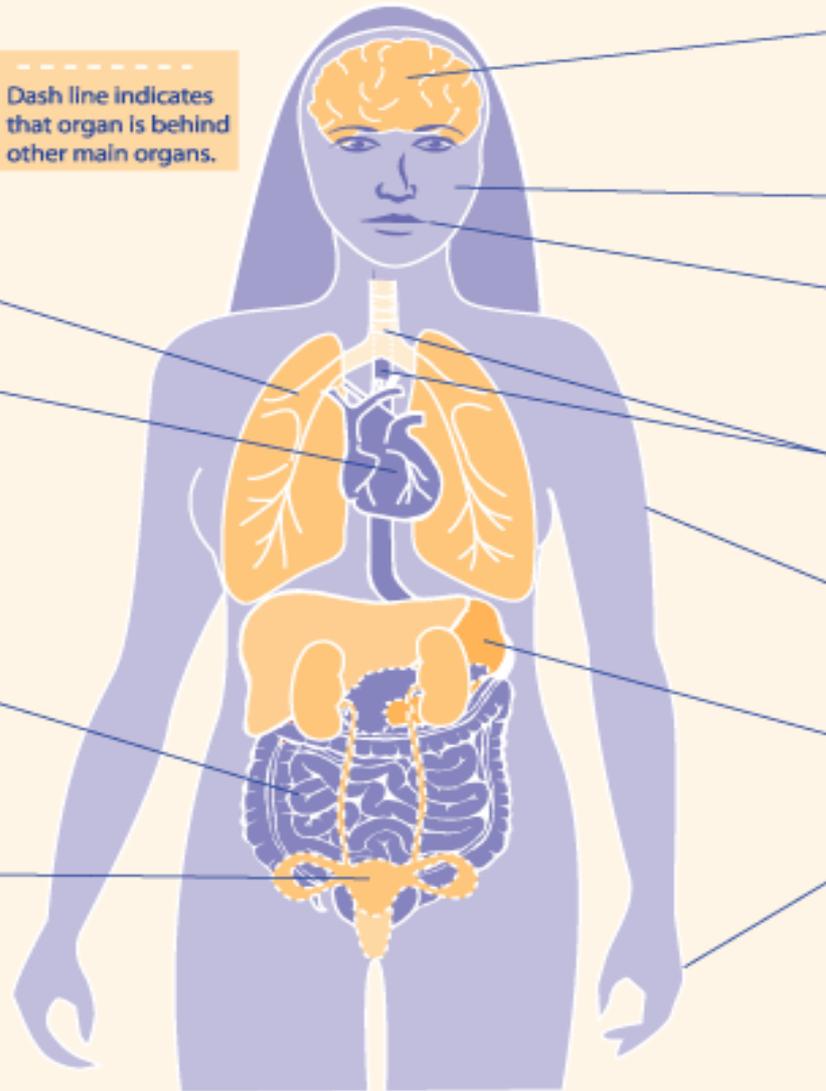
dehydration, low potassium, magnesium, and sodium

Intestines

constipation, irregular bowel movements (BM), bloating, diarrhea, abdominal cramping

Hormones

irregular or absent period



5) Binge Eating Disorder in DSM-5



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 based on number of binge-eating

6) Other Specified Feeding or Eating Disorders

1. Atypical anorexia nervosa- All of the criteria met except that weight is normal
2. Bulimia nervosa (of low frequency and or limited duration)- All of the criteria, but episode less than 1x a week and/or less than 3 months
3. Binge-eating disorder (of low frequency and/or limited duration)- Same as above
4. Purging disorder-Recurrent purging behavior to influence weight or shape in the absence of binge eating
5. Night eating syndrome- Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal

Risk Factors

1) Biological

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

2) Psychological

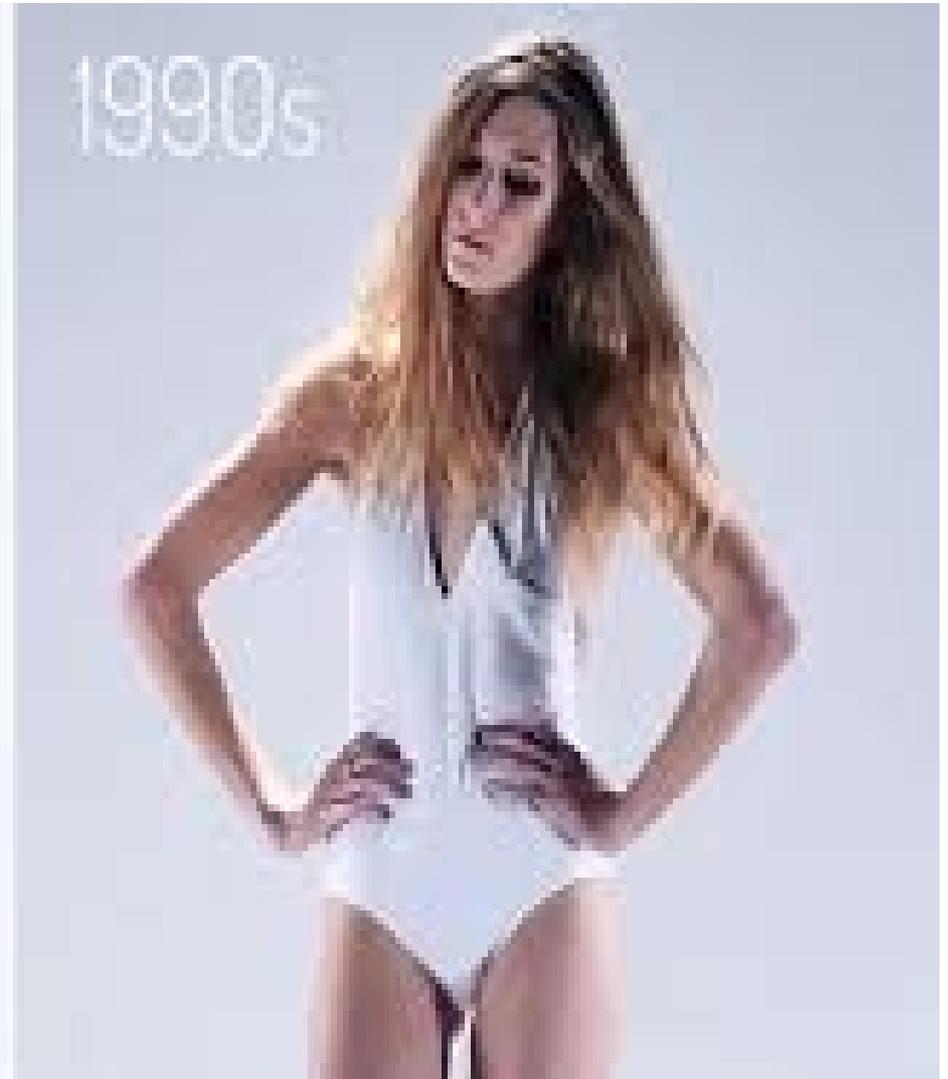
- Comorbid psychiatric disorders (i.e., depression, anxiety)
- Traits such as perfectionism, obsessionality, excessive compliance, low self-esteem, negative affect/attitude
- Body dissatisfaction and distortion
- Poor social skills and isolation
- Low motivation

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



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
SSRIs- antidepressant; effective when anxiety or depression is also present	

Interventions	Effectiveness
Family-based therapy More effective than individual therapy; helping parents unite and stand up to an externalized illness and refed their adolescent	
Motivational Interviewing A client-centered, collaborative, but directive method is effective because people with anorexia are not motivated to change	
CBT (schema therapy) Changing dysfunctional core belief systems into functional schema	
Psychoeducation for caregivers 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 Floxistine(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 Changing dysfunctional core belief systems into the functional schema	
Interpersonal therapy Developed for depression, but used for adolescents with BN; focus on interpersonal issues	
Family-Based Therapy Effective for adolescents	

Interventions for Binge Eating Disorder

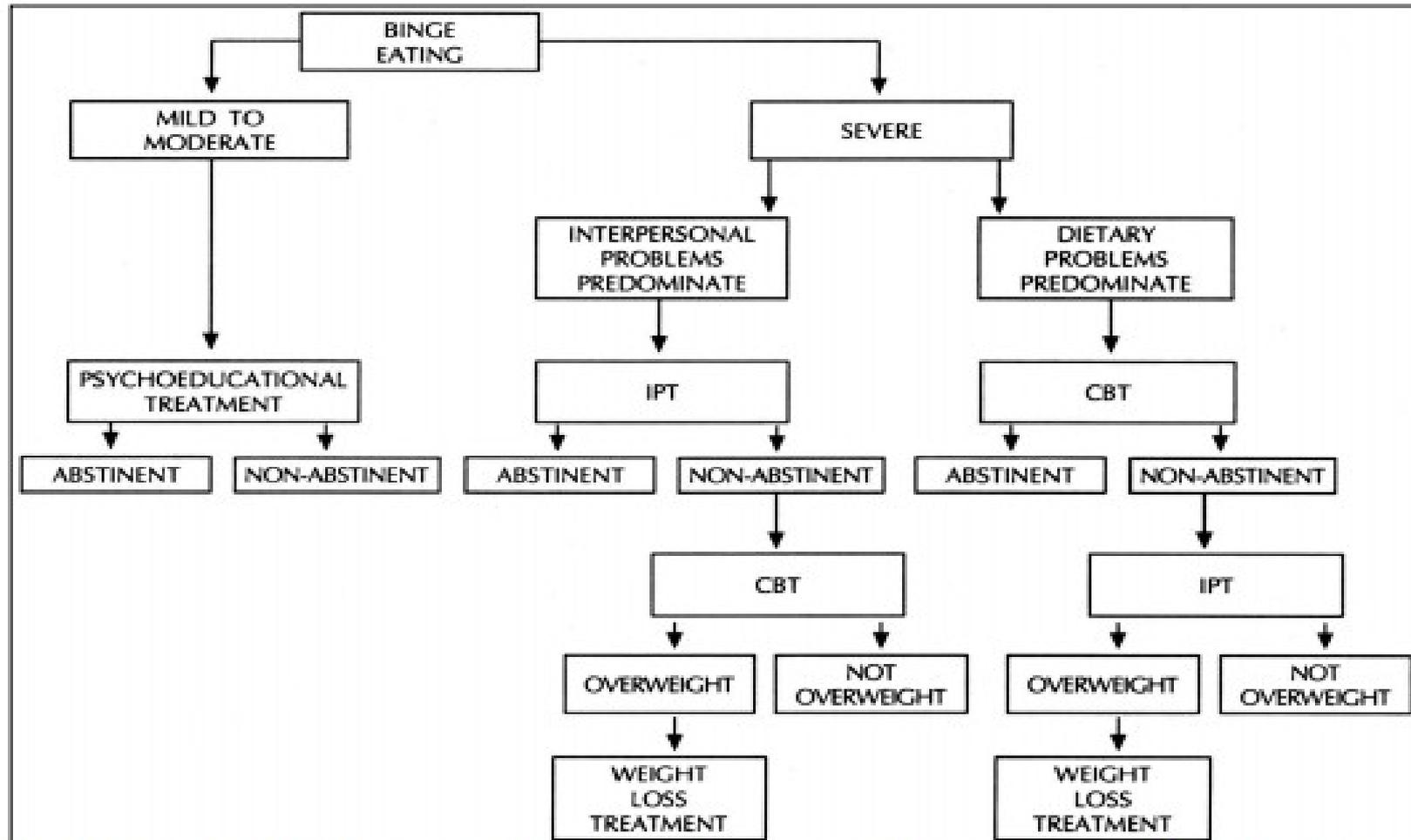


Fig. 3. A flow chart illustrating a hypothetical comprehensive model of the psychological treatment of binge eating.

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.

CBT-E resources

Handouts from *Cognitive Behavior Therapy and Eating Disorders*

[F2.3 - CBT-E formulation of bulimia nervosa](#)

[F2.4 - CBT-E formulation of “restricting” anorexia nervosa](#)

[F2.5 - Transdiagnostic CBT-E formulation](#)

[T4.2 - Points to make when describing CBT-E](#)

[T5.1 - Topics to cover when assessing the eating problem](#)

[F5.2 - CBT-E formulation of eating disorder NOS in the patient's own words](#)

[T5.2 - Instructions for self-monitoring](#)

[F5.3 - Blank monitoring record](#)

[T6.1 - Topics to cover when educating patients about eating disorders](#)

[T6.2 - Patient handout on regular eating](#)

[F8.3 - Over-evaluation of control over shape and weight – an extended formulation](#)

[F8.5 - Feelings of fatness](#)

[F9.3 - Over-evaluation of control over eating – an extended formulation](#)

[F10.2 - Binge analysis](#)

[F11.2 - CBT-E formulation of binge eating / purging anorexia nervosa](#)

[T11.2 - Patient handout on the effects of being underweight](#)

[T12.1 - Short-term maintenance plan](#)

[T12.2 - Long-term maintenance plan](#)

[F13.1 - Transdiagnostic CBT-E formulation with clinical perfectionism added](#)

[F13.2 - Over-evaluation of achieving and achievement – an extended formulation](#)

[F13.3 - CBT-E formulation of bulimia nervosa with core low self-esteem added](#)

Reference

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