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Diagnosis and Individual Psychotherapy of Eating Disorders

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Anorexia Nervosa (AN)

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A) Restriction of energy intake relative to requirements leading to a *significantly low body weight* in the context of age, sex, developmental trajectory, and physical health.

B) *Intense fear of gaining weight* or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight

C) Disturbance in the way in which one's *body weight or shape is experienced*, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Anorexia Nervosa "Severity"

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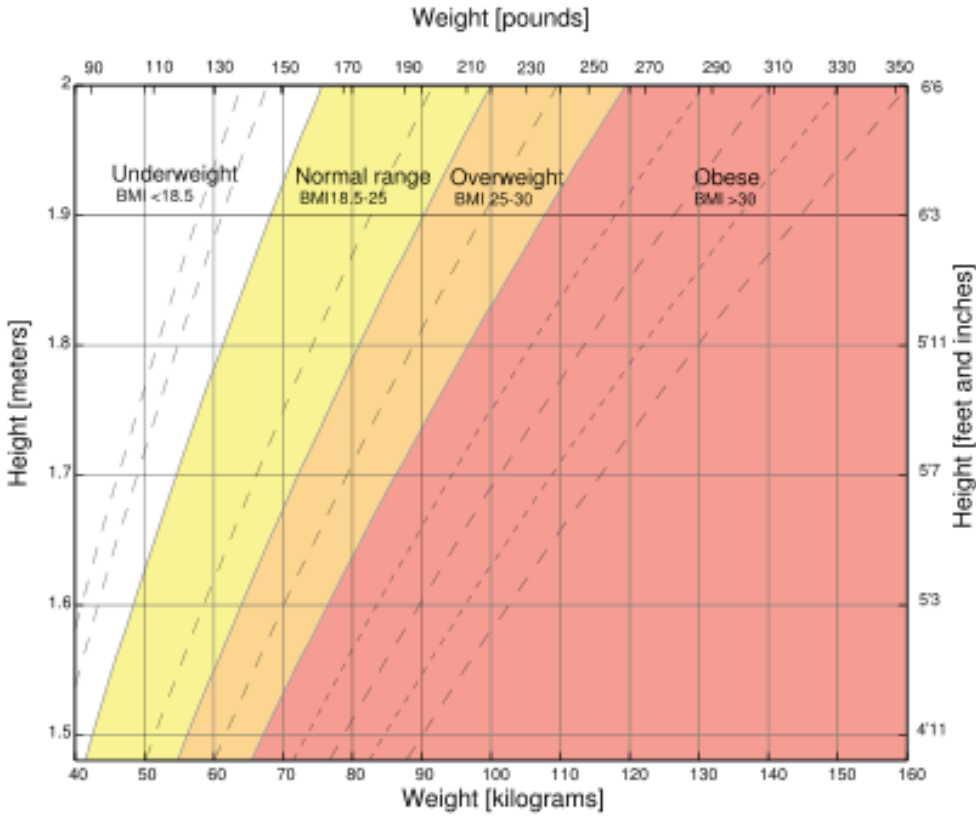
Body Mass Index (BMI):
weight (kg)/height^2 (m^2) or 703×weight (lb)/height^2 (in^2)

- Anorexic: *generally* < 17.5 kg/m^2
  - Mild: ≥ 17
  - Moderate: 16 -16.9
  - Severe: 15 -15.9
  - Extreme: < 15
- Underweight: < 18.5
- Ideal: 18.5 - 24.9
- Overweight: 25.0 - 29.9
- Obese: 30 - 40
- Morbidly Obese: over 40



Anorexia Nervosa Subtypes

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A) Restricting Type

Weight loss accomplished primarily by dieting, fasting, and/or excessive exercise

B) Binge-Eating/Purging Type

Weight loss accomplished by binge eating and/or purging, e.g. self-induced vomiting, use laxatives, diuretics or enemas

Anorexia Nervosa: Remission Specifiers

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- *In partial remission*: After full criteria for AN were previously met, **criterion A** (low body weight) has not been met for a sustained period of time, but either **criterion B** (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or **criterion C** (disturbances in self-perception of weight and shape) is still met.

- *In full remission*: After full criteria for AN were previously met, none of the criteria have been met for a sustained period of time.

Anorexia Nervosa Mortality

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- Highest mortality rate of any psychiatric disorder
- 5% per decade of follow-up
- Standardized mortality ratio 6.2-10.5
- Suicide (SMR 56.9; 95% CI, 15-146)
- BMI < 13kg/m^2 increased risk for sudden cardiac death

Keel PK et al Arch Gen Psychiatry 2003 Feb;60(2):179-83; Pisetsky EM et al J Abnormal Psychol. 2013 Nov; 122(4); 1041-56

Bulimia Nervosa (BN)

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A) Recurrent episodes of *binge eating*

1. Eating, in a discrete period of time, 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* to prevent weight gain (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise)

C) Binge eating and compensatory behavior both occur, on average, at least once a week for 3 months

D) Self-evaluation is unduly influenced by body shape & weight

E) Does not occur exclusively during episodes of AN

BN Specifiers

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- DSM-5 has the clinician determine level of severity using the following criteria:
  - Mild: 1-3 episodes of inappropriate compensatory behavior per week
  - Moderate: 4-7 episodes per week
  - Severe: 8-13 episodes per week
  - Extreme: 14 or more episodes per week

- Full vs. Partial Remission
  - *In partial remission*: After full criteria for BN were previously met, some but not all, of the criteria have been met for a sustained period of time
  - *In full remission*: After full criteria for BN were previously met, none of the criteria have been met for a sustained period of time.

Binge Eating Disorder (BED)

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A) Recurrent episodes of binge eating (same as BN)

B) 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 embarrassment
5. Feeling disgusted with oneself, depressed, or very guilty after overeating

C) Marked distress regarding binge eating is present

D) At least once a week for 3 months

E) Binge eating is not associated with the recurrent use of inappropriate compensatory behavior

BED Specifiers

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- DSM-5 has the clinician determine level of severity using the following criteria:
  - Mild: 1-3 episodes of binge-eating per week
  - Moderate: 4-7 episodes per week
  - Severe: 8-13 episodes per week
  - Extreme: 14 or more episodes per week

- Full vs. Partial Remission
  - *In partial remission*: After full criteria for BED were previously met, binge eating occurs at an average frequency of less 1X/wk for a sustained period of time
  - *In full remission*: After full criteria for BED were previously met, none of the criteria have been met for a sustained period of time.

Other Specified Feeding or Eating Disorder

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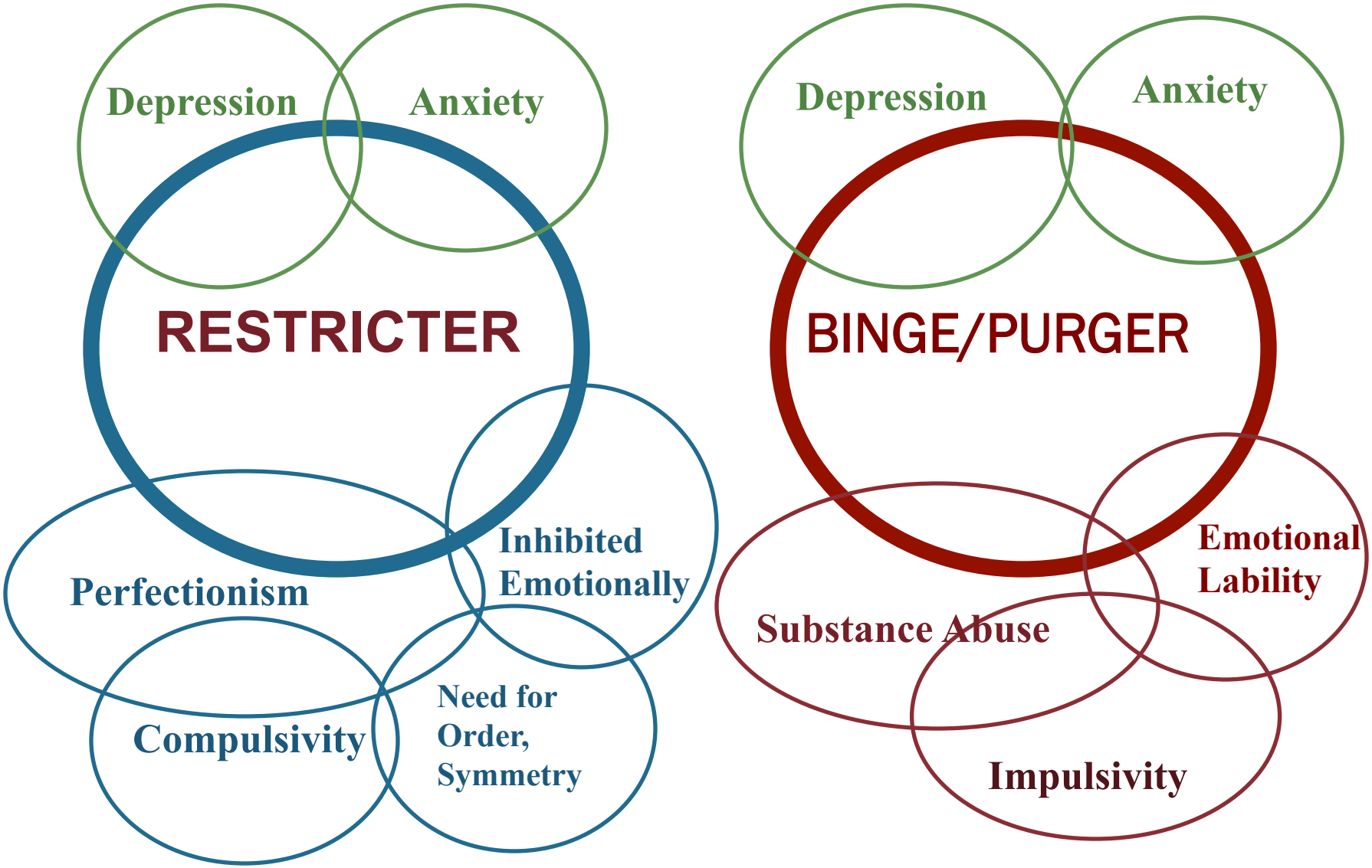
- Atypical AN – despite significant weight loss, weight remains within or above normal weight range
- BN (of low frequency and/or limited duration)
- BED (of low frequency and/or limited duration)
- Purging disorder– recurrent purging to influence shape or weight in absence of binge eating
- Night eating syndrome – recurrent episodes of night eating (eating after awakening from sleep or by excessive food consumption after evening meal)

Psychiatric Comorbidity



Transdiagnostic Model of EDs

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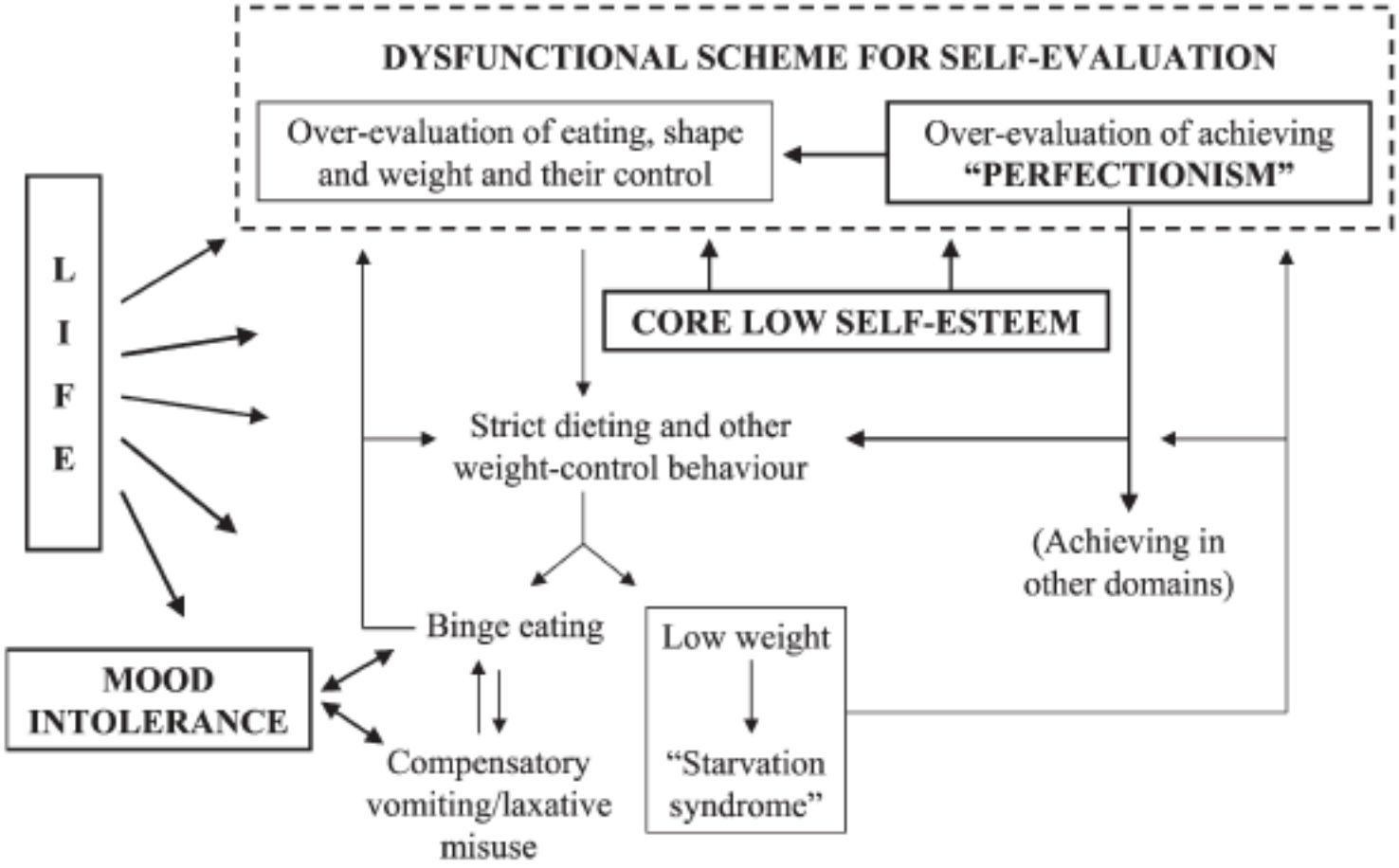

Fairburn, CG et al. BRAT 2003; 41: 509-529

Anorexia Nervosa Treatment

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Phase I

Immediate goal: weight restoration

- Frequently requires inpatient hospitalization

Increase caloric intake

- Organize/normalize eating
- Increase amount and types of food
- Specific meal plan/set eating change goals
- Monitor via "food records"

Regular weighing - regular feedback re: weight is correlated with more positive outcome

Guidance, education, reassurance and validation

Attia E & Walsh BT. N Engl J Med 2009;360:500-6.

Anorexia Nervosa Treatment Cont

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Phase II

- Long(er) Term Goal: Address psychological issues through individual, group, and/or family therapy
  - Target distorted cognitions and body perception
  - Address concomitant psychiatric and medical problems
  - Teach healthier ways to exert autonomy and control
  - Improve ability to access and identify feelings, needs, and opinions
  - Decrease need to "speak through the denial of food"

- Relapse prevention

Psychotherapy for AN

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- **Enhanced Cognitive Behavioral Therapy (CBT-E)**
  - Some efficacy for CBT-E in adult outpatients[1]
    - 63% completed treatment (40 weeks)
    - Of those who completed, 62% were normal weight* at post-treatment, 55% at 60-week follow-up
    - Significant decrease in ED related psychopathology
  - CBT-E may prevent relapse in weight-restored AN [2]

- **Cognitive Remediation Therapy (CRT)**
  - Computerized adjunctive intervention
  - Shown promise in targeting neuropsychological deficits common in AN (flexibility, local vs. global processing)

[1]Fairburn et al., Behav Res Ther 2013; 51, R2-R8; [2]Carter JC et al., Int J Eat Disord; 2009;42:202-7[3] Couturier J et al., Int J Eat Disord 2013;46:3-11

Treatment of Bulimia Nervosa and BED

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Phase I: Disrupt diet-binge-purge cycle

Establish regular pattern of eating

Normalize amounts and types of food

Phase II: Explore function of eating disorder behavior/ Develop alternatives/ Address associated issues

Breaking the Cycle

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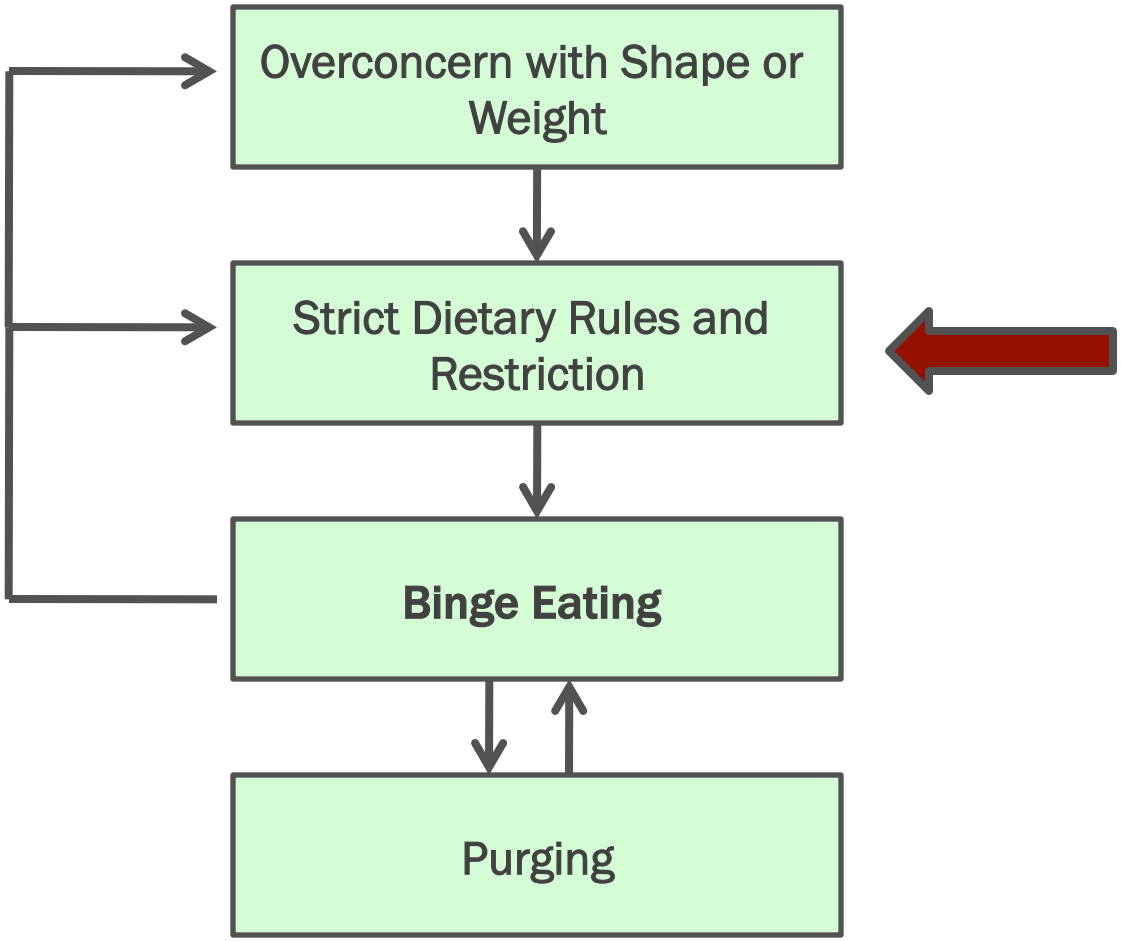

Psychotherapy for Bulimia Nervosa

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- CBT-E effective for decreasing binge and purge frequency
  - Approximately 50% are able to stop binge/purge behavior, the majority (~80%) are able to reduce behavior
  - Rapid response predicts treatment outcome
  - If no response after 10 sessions add fluoxetine
  - Focused vs. Broad approaches

- Interpersonal Psychotherapy (IPT) is an evidenced based alternative to CBT-E
  - Takes longer than CBT to achieve comparable effect

Wilson GT & Fairburn CG 2007; APA, Am J Psychiatry 2006;163(7 Suppl):4-54.

Psychotherapy for Binge Eating Disorder

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- CBT has strong empirical support
  - Remission rates as high as 70%; CBT+ placebo superior to fluoxetine-only. Addition of fluoxetine to CBT does not improve results.[1]
  - Does not help weight loss
  - Some evidence for long-effectiveness [2]
  - Self-help option (Guided Self-Help; GSH)

- GSH-based on CBT or IPT superior to behavioral weight loss treatment at 2 years

[1]Grilo et al. Biol Psychiatry 2005; 57 (3): 301-309; [2] Grilo et al. JCCP 2012: 80 (6) 1108-13.
Reas DL & Grilo CM, Obesity 2008;16:2024-38; Wilson GT et al., Arch Gen Psychiatry 2010;67:94-101.

Recent Developments in ED Treatment

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- Acceptance and Commitment Therapy (ACT)
  - Teaches patients to defuse from distressing internal experiences
  - Promotes acceptance of difficult thoughts and emotions
  - Replaces ineffective avoidance/control strategies with more constructive values-consistent behaviors

- Unified Transdiagnostic Treatment Approaches