Chapter 15: Feeding and Eating Disorders

# 15.1 Feeding Disorders in Young Children

## What is Pica and Rumination Disorder?

* Pica is a DSM-5 feeding disorder characterized by the persistent eating of nonnutritive, nonfood substances that is developmentally and culturally unexpected. It lasts at least one month.
* Rumination Disorder is a DSM-5 feeding disorder characterized by repeated regurgitation of food. It occurs over the period of at least 1 month and must not be attributable to a medical condition or an eating disorder.

## What is Avoidant/Restrictive Food Intake Disorder?

* ARFID is a DSM-5 feeding disorder characterized by (1) a lack of interest in feeding, (2) avoidance of food based on its sensory qualities, or (3) concerns about the negative consequences of eating. It causes weight loss, nutritional deficiencies, or other health/social impairment.
* The transactional model posits that feeding disorders arise through parent-child interactions characterized by children with (1) high physiological arousal and (2) difficult temperament, and (3) parents who are anxious about their child’s food intake.
* Approximately 1-2% of infants and toddlers have ARFID. Prevalence is higher among children with medical illnesses, developmental disabilities, and physical disabilities.

## What Treatments Are Effective for Feeding Disorders?

* Positive reinforcement is the preferred treatment for Pica. Positive punishment, such as overcorrection or facial screening can be used with parental consent if positive reinforcement is not sufficient to reduce potentially dangerous ingestion.
* The treatment of ARFID can include (1) appetite manipulation to increase children’s motivation to eat, (2) contingency management to reinforce eating and avoid escape conditioning, and (3) parent counseling to help generalize skills to the home.
* Behavioral interventions are highly effective for young children with feeding disorders.

# 15.2 Eating Disorders in Older Children & Adolescents

## What Eating Disorders Can Affect Children & Adolescents?

* Anorexia Nervosa is a DSM-5 eating disorder characterized by (1) caloric restriction leading to significantly low body weight, (2) intense fear of gaining weight or becoming fat, and (3) disturbance in one’s body weight or shape.
* Bulimia Nervosa is a DSM-5 eating disorder characterized by (1) recurrent episodes of binge eating, (2) recurrent inappropriate compensatory behaviors to prevent weight gain, and self-evaluation that in unduly influenced by one’s body shape or weight. It occurs at least once/week for at least three months.
* Binge Eating Disorder is a DSM-5 eating disorder characterized by (1) recurrent episodes of binge eating, (2) associated features (e.g., eating rapidly, eating when depressed, feeling ashamed) and (3) marked distress. It occurs at least once/week for at least three months.

## What Conditions Are Associated with Eating Disorders?

* Medical complications associated with AN/BN include electrolyte imbalance, osteopenia, cardiac problems, malnutrition, dry skin, lanugo, enlarged salivary glands, and damage to esophagus and teeth. Youths with BED are at risk for obesity.
* Adolescents with AN/BN are at risk for depression and self-injury, anxiety and obsessive-compulsive behaviors, and substance use problems.
* Adolescents with AN often show perfectionism, a personality trait characterized by a rigid and unrealistic pursuit of absolute standards and may engage in dichotomous (black-or-white) thinking.
* Girls with AN/BN often come from families characterized by low autonomy, high conflict, and preoccupation with body shape and weight.

## How Common Are Eating Disorders in Children & Adolescents?

* The lifetime prevalence of AN is 0.5% to 1% of females and less than 0.3% of males. The lifetime prevalence of BN is 1.5% to 4% of females and less than 0.5% of males. The lifetime prevalence of BED is 2.6%.
* Recent research suggests that eating disorders exist across countries and cultures. Adoption of western cultural values and acculturation into the United States is associated with the onset of eating disorders.
* Onset of AN is typically between 16 and 19 years; onset for BN is often between 18 and 20 years. AN is associated with more severe and lasting impairment.
* The course of BED often depends on the age of symptom onset. Childhood-onset BED is associated with a history of childhood obesity, binge eating, and dieting; and greater risk for depression and family problems in later adolescence and adulthood.

## What Causes Child/Adolescent Eating Disorders?

* Both AN and BN have heritability estimates ranging from approximately .50 to .75. The neurotransmitter serotonin is implicated in both AN and BN and may explain why SSRIs are effective in reducing anxiety and negative affect associated with these disorders.
* Child sexual abuse is a nonspecific risk factor for eating disorders; sexual maltreatment predicts a wide range of disorders, not only eating problems.
* The cognitive-behavior model posits that bingeing in negative reinforced by a reduction in hunger whereas purging and other compensatory behaviors are negative reinforced by reduced feelings of guilt.
* Social-cultural theories for eating disorders include the dual pathway model (i.e., dietary restriction, negative affect) and the tripartite influence model (i.e., peers, parents, media). At the center of both models is an adolescent’s pursuit of an unrealistic thin ideal.

# 15.3 Evidence-Based Treatment for Eating Disorders

## What Treatments Are Effective for Youths with Anorexia Nervosa?

* The primary goal of inpatient treatment for AN is weight gain. Staff members administer behavioral protocols that usually involve positive reinforcement for eating and response cost for failing to achieve goals for caloric intake.
* Group therapy for AN often relies on supportive collaboration in which senior group members challenge the cognitive distortions and food obsessions of newer members.
* Structural family therapy is sometimes used to improve parent-adolescent communication and to help parents meet adolescents’ needs for greater autonomy.
* The Maudsley Hospital approach to treatment involves (1) initial refeeding by parents, (2) structural family therapy to improve communication, and (3) increased autonomy for the adolescent.

## What Treatments Are Effective for Youths with Bulimia Nervosa?

* The primary goals of cognitive-behavioral therapy BN is (1) to expose youths to normal food intake while restricting compensatory behaviors, and (2) identify and challenge cognitive distortions that might elicit negative emotions and trigger maladaptive eating.
* Interpersonal therapy is based on the notion that relationship problems often coincide with and exacerbate eating disorders. Therapists help youth identify and overcome problems related to (1) grief, (2) role transitions, (3) rule disputes, and (4) interpersonal deficits.
* SSRIs are effective in reducing symptoms of BN in adolescents. Combining SSRIs with CBT is more effective than administering SSRIs alone.

## What Treatments Are Effective for Youths with BED?

* Cognitive-behavior therapy is effective in reducing symptoms of BED in children and adolescents. Therapy typically involves helping youths identify situations and negative emotions that trigger binge eating and challenging cognitive distortions that can lead to negative affect.
* Interpersonal therapy is also effective in reducing binge eating. Therapists help youths overcome interpersonal problems that can cause depression, loneliness, or social isolation that can lead to binges.