The diagnosis and classification of feeding and eating disorders in children and young people
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Scottish CAMHS Eating Disorders Steering Group 2014
Nothing to disclose
Are Eating Disorders an important area?

- 3rd most common chronic overall disorder in adolescents/young women
  - Lucas et al 1991/1999 (Minnesota study)
- AN has highest mortality rate of any psychiatric disorder in this age group
- Increasing???
Why learn more about diagnosis and classification?

- My own clinical practice
- Communication between clinicians
- Patients and families/carers
- Service implications
- Research/evidence
- Changes in diagnostic classification systems used
Learning objectives:

• To recognise the main feeding and eating disorders in children and adolescents
• To understand the current and changing diagnostic classification systems commonly used
• To consider the above from different perspectives
Overview

• Intro and background
• Descriptions of main diagnoses
• Classification systems and implications
• Practice
• Different perspectives
• Summary and conclusions
Pica (in DSM-5 and ICD 10 under FDoIC)

- Persistent eating of non-nutritive substances (non-food or raw food) – soil, clay, ice, paper, faeces...
- Excludes culturally sanctioned practices eg soil in African cultures and in children under 2 years
- May occur in people with learning disability and/or autistic spectrum disorders (ASD) or pregnancy
Rumination disorder (in DSM-5 and ICD-10 under FDoIC)

• Repeated regurgitation of food that has been swallowed – swallowed or spat out
• No undue effort or nausea
• Frequent and sustained
• May have emotional regulation function
• Often secretive
ARFID
Avoidant/Restrictive Food Intake Disorder (in DSM-5)

• Eating or feeding disturbance manifested by persistent failure to meet appropriate nutritional and/or energy needs and leading to ONE or more of the following:
  – Significant weight loss (or failure to achieve expected weight gain or faltering growth in children)
  – Significant nutritional deficiency
  – Dependence on enteral feeding or oral nutritional supplements
  – Marked interference with psychosocial functioning
ARFID – What it is not

• NOT the result of lack of available food or an associated culturally-sanctioned practice
• NOT associated with any abnormalities in the way in which one perceives their body weight or shape
• NOT explained by another medical or mental disorder so that if you treat it the eating problem will go away
Anorexia nervosa
(in ICD 10 and divided into Restricting or Binge/purge subtypes in DSM-5)

• Restriction of food intake relative to requirements leading to significantly low body weight in context of age, sex, developmental trajectory and physical health

• Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight

• 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
Bulimia nervosa (ICD 10 and DSM-5)

• Binge eating episodes (recurrent episodes eating large amounts accompanied by a sense of control)

• Inappropriate compensatory behaviours (self-induced vomiting, laxative or other substance/medication misuse, excessive exercising and fasting)

• Binge and inappropriate compensatory behaviours both occur on average at least once a week for 3 months
Binge Eating disorder (BED)- in DSM-5

• Recurrent episodes of binge eating (1 X/week for 3 months)
• Associated with 3 or more of the following
  – Eating rapidly
  – Feeling uncomfortably full
  – Large amounts when not hungry
  – Feeling embarrassed
  – Feeling depressed or guilty
• Marked distress re: binge eating
• No recurrent use of inappropriate compensatory behaviours
“Other” feeding and eating disorders and disturbances

• Atypical
• Subthreshold
• Purging disorder and night eating syndrome (mainly in adults)
• Selective eating/restrictive eating (GOS)
Break

• Scenarios
Different classifications used:

- International classification of diseases (ICD)
- Diagnostic and statistical manual of mental disorders (DSM)
- Great Ormond Street (Bryant-Waugh and Lask 2013)
- Rome III (functional gastrointestinal disorders)
- Zero to Three (infants feeding disorders)
Rome Foundation

• A good diagnostic classification system provides a common language in which clinicians, researchers, families and healthcare policy makers can communicate transcending the terminology of their own specialties.
ICD -10 1994 (5th version 2016)
43 countries
CHAPTER V - Mental and behavioural disorders (F01-F99)

This chapter contains the following blocks:
- F01-F09 Mental disorders due to known physiological conditions
- F10-F19 Mental and behavioural disorders due to psychoactive substance use
- F20-F29 Schizophrenia, schizotypal and delusional, and other non-mood psychotic disorders
- F30-F39 Mood [affective] disorders
- F40-F48 Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
- F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors
- F60-F69 Disorders of adult personality and behaviour
- F70-F79 Mental retardation
- F80-F89 Pervasive and specific developmental disorders
- F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- F99 Unspecified mental disorder
ICD-10

• **AN (F50.0)** – all following required:
  – low body weight (BMI<17.5 or 15% less than expected, prepubertal pts failure to make expected weight gain)
  – Self-induced wt loss
  – Body-image distortion ("dread of fatness")
  – Endocrine disorder – HP axis – amenorrhoea in women and in men loss of sexual interest and potency
  – If onset prepubertal delay of puberty or arrested growth

• **Atypical AN (F50.1)** – one of key criteria absent - milder
• **BN (F50.2)** - preoccupation with eating, irresistible craving, overeating (large amounts of food in short time), attempts to counteract “fattening effects” of food (by vomiting, purgatives, alternating periods starvation, use of drugs, thyroid, diuretics, insulin), morbid dread of fatness

• **Atypical BN (F50.3)** - one or more key feature is absent, milder

• **Overeating assoc with other psychological disturbances F50.4**

• **Vomiting assoc with other psychological disturbances F50.5**

• **Other eating disorders F50.8** (pica, psychogenic loss of appetite)

• **Eating disorder, unspecified F50.9**
F98: Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence

- F98.2 Feeding disorder of infancy and childhood – refusal of food and extreme faddiness +/- rumination. Includes rumination disorder of infancy

- F98.3 Pica of infancy and childhood
American Psychiatric Association

DSM-IV to DSM-5

• Conceptual
• Structural
• Diagnostic
DSM-IVR to DSM-5: conceptual

• The goal of the DSM-5 Eating Disorders working group
  – To make feeding and eating disorders recognizable to non-psychiatrists to facilitate better diagnosis by clinicians
  – Adopt a lifespan approach
  – Age and stage influence on symptoms
  – Allow for updates and integration new findings
DSM-5 *NOT* DSM-IV

- Allows for updates and integration of new findings
- DSM-5.1
DSM-IV to DSM-5: Structural

- Multi-axial system discontinued:
  - To recognise the main feeding and eating disorders in children and adolescents
  - Axis I: Clinical disorder
  - Axis II: General medical
  - Axis III: Psychosocial and environmental problems
  - Axis V: Global assessment of functioning
- Incompatible with rest of medicine
- Consistent with WHO and ICD guidelines
DSM-IV to DSM-5: Diagnostic

Feeding Disorders of Infancy and Early Childhood

Eating Disorders

Feeding and Eating Disorders
DSM-IV to DSM-5: Diagnostic Eating disorder diagnostic challenges

• >50% of children and adolescents do not meet full criteria
• “Refusal” to maintain weight implies pejorative motivation
• Not developmentally sensitive
  – Children should not maintain/lose a small amount of weight
  – Children and young adolescents do not experience their body in the same way adults do- cognitive development
  – Children and young adolescents may not have reached menarche
DSM-IV to DSM-5: Diagnostic

- Feeding disorder of infancy and early childhood diagnostic challenges
  - Rarely used
  - Limited info available on the characteristics, course and outcome of these children
  - This diagnostic criteria was not exclusively seen in young people ,6 yrs
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<thead>
<tr>
<th>DSM-IV criteria</th>
<th>DSM-5 criteria</th>
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<tbody>
<tr>
<td>AN- suggested weight cut-offs + amenorrhoea (&gt;=3 mths)</td>
<td>AN – amenorrhoea and numerical weight cut-offs eliminated; developmental considerations incorporated</td>
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<tr>
<td>BN – binging and purging &gt;=2/week for &gt;=3 mths</td>
<td>BN – binging and purging 1X/week for &gt;=3 mths</td>
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<tr>
<td>Eating Disorder Not Otherwise Specified included BED in appendix – binging &gt;=2/week for 6 months</td>
<td>BED – binging 1X/wk for 3 mths</td>
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<td>DSM-IV criteria</td>
<td>DSM-5 criteria</td>
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<td>EDNOS</td>
<td>EDNOS eliminated</td>
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<td><strong>ARFID</strong></td>
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<td>Other specified Eating disorders (OSFED):</td>
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<td></td>
<td>- Atypical AN (not underweight)</td>
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<td>- Purging disorder</td>
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<td>- Sub-threshold BN</td>
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<td>- Sub-threshold BED</td>
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<td>- Night eating syndrome</td>
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<td><strong>Unspecified Feeding and Eating Disorders (USFED)</strong></td>
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<td>Feeding Disorder of Infancy or</td>
<td>Feeding Disorders of Infancy or Early Childhood eliminated</td>
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<td>Early Childhood</td>
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<td><strong>Pica</strong></td>
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<td><strong>Rumination</strong></td>
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Why bother?

• Who’s interested?

• What does it mean?

• Pro’s and con’s? Limitations of diagnosis? Effect on engagement?

• Unintended consequences?
  • (Biographical disruption)

• Effect of stigma?
Break

• Turn to neighbour
• Consider experience of being given bad news
• Feelings/thoughts/implications
Stages of grief

Elisabeth Kubler-Ross

- Shock/Denial – “it can’t be true, it is unreal, life goes on” Initial paralysis at hearing the bad news
- Anger - What the ~@** is happening? How dare they etc.
- Bargaining – If we can only do this or that, things will be all right tomorrow
- Depression - Reality is still with us, can’t shake it away
- Testing/Acceptance – Seeking realistic solutions/ let’s do the best we can
Goffman (1963)
“Stigma is a process by which the reaction of others spoils normal identity”

http://www.time-to-change.org.uk/what-is-stigma
Effects

• Isolates people
• Excludes from day to day activities
• Stops people from getting and keeping jobs
• Prevents people seeking help
• Negative impact on physical health
The experience of stigma in individuals with eating disorders, parents and siblings: results of three online surveys
Beat Stigma Project group
ICED 2015 Bryant-Waugh et al

- Majority of families are significant negatively affected by the experience of eating disorders stigma
- This adds significantly to the burden of families
- Nearly one third of mental health professionals were identified as perpetuating stigma related to eating disorders

.................................................
Conclusions/recommendations:

• Improving understanding of eating disorders
• Providing better education
• Increasing awareness
Marie Curie

• “Nothing in life is to be feared, it is only to be understood. Now is the time to understand more, so that we may fear less.”
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Thank You