

EATING DISORDERS

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Eating disorders (EDs) are conditions characterized by eating-related difficulties that result in significant medical and/or psychosocial impairment. The symptoms of EDs included in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5*; American Psychiatric Association, 2013) are summarized in Table 23.1. This chapter focuses on three EDs (anorexia nervosa [AN], bulimia nervosa [BN], and binge-eating disorder [BED]), plus other specified feeding and eating disorder [OSFED] and avoidant/restrictive food intake disorder [ARFID].

All EDs are serious psychiatric conditions that significantly decrease quality of life and result in high rates of medical complications, including death (Klump et al., 2009). Despite their substantial morbidity and mortality, knowledge related to psychological treatment of EDs is limited. This is likely due to multiple factors, including low funding for ED research and relatively recent attention to and identification of EDs by the medical and psychiatric communities. More research is especially needed to understand how EDs affect people across culture, race, ethnicity, socioeconomic status, genders, sexual orientation, and other factors related to diversity. This chapter aims to summarize the historical and current state of psychological treatment for AN, BN, BED, OSFED, and ARFID as well as describe future

directions to improve efficacy, effectiveness, and access to quality psychological care.

GENERAL PSYCHOTHERAPIST COMPETENCIES AND SKILLS NECESSARY TO TREAT EDs

Experts agree that specialized competencies are necessary to provide psychological treatment to people with EDs, and training and experience is needed to manage these often-dangerous conditions (Spotts-De Lazzer & Muhlheim, 2016). Recently, the Australia and New Zealand Academy for Eating Disorders published recommendations for provider training and competencies (Heruc et al., 2020). Their list of nine general principles is widely accepted as best practice among experts in the field:

1. Early intervention is essential.
2. Coordination of services is fundamental to all treatment settings and across the patient's lifespan.
3. Evidence-based treatment is essential.
4. Support persons should be involved in service provision, including family or guardians for youth and significant others for adult patients.
5. Treatment should be personalized in terms of treatment intensity (e.g., match treatment intensity with current patient needs/

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TABLE 23.1

Eating Disorder Diagnoses Featured in *DSM-5*

	Anorexia nervosa	Bulimia nervosa	Binge-eating disorder	Avoidant/restrictive food intake disorder (ARFID)	Pica	Rumination disorder
Energy restriction	R	C	C	R^a		
Fear of weight gain or becoming fat	R^b	C	C	E		
Persistent behavior that interferes with weight gain	R^b	C	C	C	C	C
Body image concerns	R	R	C	E		
Recurrent binge eating	C	R	R			
Recurrent compensatory behaviors	C	R	E			
Eating nonfood substances					R	
Recurrent regurgitation						R

Note. C = common or possible diagnostic feature, though not required to make diagnosis. *DSM-5* = fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. E = Exclusion criterion; if this feature is present, this diagnosis cannot be given. R = Required feature for diagnoses.

^aIn ARFID, restriction can present as overall energy restriction (i.e., undereating) or failure to meet nutritional needs even if caloric needs are being met via preferred foods. ^bFor anorexia nervosa, one of these two columns is required (i.e., patient must demonstrate fear of weight gain, OR fear of becoming fat, OR persistent behavior that interferes with weight gain).

presentation, and be prepared to scale up or down as necessary).

6. Treatment should integrate important cultural and family considerations (e.g., race, ethnicity, body size, age, sexuality, and gender) and assume a strengths-focused approach supporting recovery and quality of life.
7. Education and psychoeducation should be included in all interventions, including an explicit effort to combat misinformation about “healthy” eating and weight.
8. Multidisciplinary care is essential.
9. Care should be provided by a skilled workforce, since expertise produces better outcomes.

Recommendations for general clinical practice standards are listed in Exhibit 23.1 (Heruc et al., 2020).

Many core features of treatment are shared across ED diagnoses, including regulation of eating patterns; weight restoration (when applicable); and interruption of ED behaviors, such as dietary restriction and restraint, binge eating, and compensatory behaviors. Evidence-based psychosocial interventions (EBPIs; treatments evaluated in randomized controlled clinical

trials [RCTs], replicated by independent research teams) for treating EDs must be adapted accordingly to be disorder-specific and shaped to the patient’s culture, diversity factors, and preferences for care (Kazdin et al., 2017). EBPI treatment adherence is quite important; after all, when deviations from evidence-based treatment protocols occur, they most often result in avoidance of effective elements that the clinician perceives will cause short-term distress for the patient (Kosmerly et al., 2015). Next, historical and current best-practice psychological treatments are reviewed for each diagnostic group.

ANOREXIA NERVOSA

Historical Perspective on Anorexia Nervosa

Coining of the term “anorexia nervosa” has been credited to either Sir William Gull, a British physician, or the French neuropsychiatrist Ernest Lasègue, as they both published works related to AN in 1873 (Vandereycken & Van Deth, 1989). These early writings on AN emphasized the importance of renourishment in the treatment

EXHIBIT 23.1

General Clinical Practice Standards From Heruc et al. (2020)

Diagnosis and assessment: Know diagnostic criteria, clinical features

Multidisciplinary care team: Medical provider, mental health professional, registered dietitian nutritionist

- Team members need clearly defined roles
- All clinicians should understand significant medical risks of eating disorders (EDs)
- Firm understanding of psychological features of behavior change
- Nutrition: target regular eating, consequences of starvation, effects of erratic or binge eating, nutritional rehabilitation
- Monitor and treat co-occurring psychiatric challenges; conduct risk assessment for self-harm/suicidal behaviors

Work to cultivate a positive therapeutic alliance

Possess skills for delivering evidence-based treatments and follow clinical practice guidelines

- Treatment is specific to patient age, diagnosis, stage of illness
- Across all interventions, clinicians should provide psychoeducation about EDs, regular in-session weighing, target regular eating, weight restoration/stability, self-monitoring, behavioral strategies to reduce ED behaviors, encourage family/support system involvement

Knowledge of levels of care treatments

- When to refer, available options for care, constant assessment
- Psychotherapy with a malnourished person (across weight spectrum) is unlikely to help with behavioral change (Hay et al., 2014)

Relapse prevention, including a management plan with 12 months of monitoring posttreatment recovery

Professional responsibility

- Clinical supervision, ongoing professional development, clinician self-care practices
- Awareness of attitudes related to body shape, weight, food
- Seek support and treatment if you are suffering

Note. Summary is adapted from “ANZAED Eating Disorder Treatment Principles and General Clinical Practice and Training Standards,” by G. Heruc, K. Hurst, A. Casey, K. Fleming, J. Freeman, A. Fursland, S. Hart, S. Jeffrey, R. Knight, M. Robertson, M. Roberts, B. Shelton, G. Stiles, F. Sutherland, C. Thornton, A. Wallis, and T. Wade, 2020, *Journal of Eating Disorders*, 8, Article 63 (<https://doi.org/10.1186/s40337-020-00341-0>). CC BY 4.0.

process (Gull, 1873), and this focus remains central to modern treatments. Indeed, all evidence-based treatments for AN explicitly focus on helping the patient to increase weight and change behaviors related to food. The need for consistent nourishment and weight restoration is based upon evidence of the role of starvation and undernourishment in maintaining the illness. The “Minnesota Starvation Study,” often cited as a foundational work on the physical and psychological effects of human starvation, provides clear parallels to the symptoms observed in individuals with AN. Researchers recruited 36 healthy men to participate in a semistarvation protocol for several months, where they were limited to 1,560 kilocalories per day (Keys et al., 1950). Several impacts of starvation on mood and behavior were observed, including increased symptoms of depression, anxiety, irritability, rigidity, food preoccupation, eating rituals, social withdrawal,

and cognitive changes (e.g., decreased judgment and concentration). Thus, many symptoms that individuals with AN experience are actually biological impacts of starvation, and can resolve with renourishment (Dalle Grave et al., 2011).

Though the essential role of renourishment in the treatment of AN persists in modern treatments, the role of individual versus family-involved treatment shifted throughout the second half of the 20th century into present day. There have been periods when individualized, psychodynamic approaches that excluded family were advocated (Bruch, 1978), but this began to change as family therapy for AN was emphasized in the 1980s and 1990s. Family treatment was later manualized to the current form of family-based treatment (FBT) for anorexia nervosa (Lock & Le Grange, 2015). Likewise, enhanced cognitive behavior therapy (CBT-E; Fairburn, 2008) encourages the involvement of families and loved ones as clinically indicated.

Given the clear consensus that renourishment is critical in the treatment of AN, the initial goal across treatments for AN is to help the patient change their behaviors toward food and eating to allow them to reach an appropriate body weight (Hilbert et al., 2017), followed by a resolution of ED cognitions and improved quality of life. Indeed, all EBPIs for AN include elements of psychoeducation for the patient and family or support persons on the effects of starvation and the expected course that weight gain will improve other domains related to recovery (e.g., anhedonia, social functioning; Hilbert et al., 2017). Explicit focus on eating and nutritional rehabilitation is key, and the expertise of a registered dietitian may be necessary (Hilbert et al., 2017). Furthermore, psychotherapists must understand medical risks accompanying AN, including risk for refeeding syndrome, which is a potentially fatal disruption in electrolytes and fluids that may occur in people who are severely malnourished as they begin to be renourished. Given this risk, close collaboration with medical care providers is critical. Finally, when treating patients with AN, sometimes intensive treatments are needed (e.g., inpatient, residential, partial hospitalization); the psychotherapist must have clear criteria for transitioning between treatment settings (Hilbert et al., 2017).

Family-Based Treatment for Anorexia Nervosa

Practice of family-based treatment for anorexia nervosa. For children and adolescents with AN, family-based treatment (FBT; Lock & Le Grange, 2015) is considered the first-line therapy. FBT is an outpatient treatment that is typically delivered across 20 psychotherapy sessions in 6 to 12 months. In FBT, the psychotherapist first provides psychoeducation to the family about the significant medical risks of the ED if it remains untreated and the need for swift behavioral change in the service of recovery. Families are encouraged to “externalize” the ED, often by giving it a name, such as “Annie” or “Ed.” Using language that separates the ED from the child is thought to reduce shame and blame

related to ED behaviors. Then, the parents or guardians in the family are tasked with the responsibility of renourishing their starving child by selecting, plating, and monitoring all food the child eats until the child is back to their pre-ED growth trajectory. Parents are also tasked with interrupting all other ED behaviors, such as excessive exercise, binge eating, purging, or cutting out particular types of food. Parents are coached to help their malnourished child to eat the amount and types of foods they need based on their level of malnutrition, versus the amount or types of food that the child's ED may feel comfortable with. For instance, if a child always loved spaghetti but stopped eating it after the onset of the ED, the psychotherapist would explicitly encourage guardians to prepare this meal, plate it for their child, and sit and eat together. Given the intensive nature of this treatment, parents who have access to medical leave often utilize this in order to more closely monitor and support their child, and it is not unusual for the child to take some time out of school. Though children with AN often initially express disapproval of this treatment plan, and extreme reactions may be produced by the ED during treatment (e.g., emotional dysregulation, attempts to get rid of food by hiding, throwing, or attempts to refuse to eat), with consistent intervention by the parents, many adolescents eventually report feeling a sense of relief that the responsibility for decision making about food has been delegated to parents, due to the anxiety the ED creates about food selection and weight restoration. As the child is nourished effectively, resistance to eating tends to decrease. In later phases of the treatment, developmentally appropriate eating independence is slowly returned to the child, and general issues of child development are addressed.

Research on FBT for Anorexia Nervosa

FBT is the treatment modality that has received the most empirical investigation in youth with AN, and numerous guidelines suggest that FBT should be first-line in youth (e.g., Academy for Eating Disorders, 2020). Despite the strong support for FBT, it is important to note that research on

treatment for adolescent AN is relatively sparse, especially compared to other common psychiatric illnesses in youth. Though there are relatively few RCTs of FBT, the trials that have been completed consistently suggest that (a) FBT facilitates more rapid weight increases than individual therapy (Lock et al., 2010) or other forms of family therapy (Agras et al., 2014; Lock et al., 2010); (b) FBT results in higher rates of remission compared with individual treatment, although there is some evidence that this difference may not emerge until 6 to 12 months posttreatment (Lock et al., 2010); (c) patients enrolled in FBT have fewer hospitalizations; and (d) FBT appears to be more cost-effective compared with alternative treatments (Agras et al., 2014; Lock et al., 2010). There is also recent evidence that a parent-focused version of FBT, in which the adolescent is not involved in the treatment sessions, is effective when compared with FBT (Le Grange et al., 2016). Though these studies support FBT as a primary intervention for adolescent AN, it is important to note that end-of-treatment remission rates are around 40%, leading to ongoing research on augmentations to FBT to further enhance outcomes; this research is in early stages.

In addition to the RCTs described above, numerous observational studies of FBT support the effectiveness of the intervention in various treatment settings, though few include comparison groups (for a review, see Couturier & Kimber, 2015). One recent, nonrandomized effectiveness investigation compared adolescent patients with AN or other restrictive EDs who enrolled in FBT versus CBT-E. Results suggested that FBT facilitated more rapid weight increases from baseline to end of treatment, though weight differences across treatments were no longer significantly different at 6- and 12-month follow-up, and psychological outcomes were similar across treatments. Though this study provided continued support for FBT, it also suggested that CBT-E may be an effective alternative treatment in adolescents (Le Grange et al., 2020). It is important to note that FBT especially needs to be investigated in people from diverse racial and socioeconomic backgrounds. Indeed, there

is a sentiment that FBT has most often been undertaken (and studied) with “highly educated, white, English-speaking families” (Accurso et al., 2021, p. 2). Research on the effectiveness of using FBT in socioeconomically disadvantaged youth with Medicaid is ongoing (Accurso et al., 2021).

Enhanced Cognitive Behavior Therapy for Anorexia Nervosa

Practice of CBT-E for AN. Enhanced cognitive behavior therapy (CBT-E) can be adapted for adults (Fairburn, 2008) and adolescents (Dalle Grave & Calugi, 2020) with AN. In CBT-E, patients are first encouraged to engage in treatment and consider behavioral changes, and obstacles to treatment are directly addressed. Daily self-monitoring of food intake is also initiated. Then, the psychotherapist proceeds through a series of consecutive steps to (a) involve patients in achieving healthy weight by regulating eating and weight gain and (b) address underlying cognitions and attitudes to make long-lasting improvements in ED psychopathology. Sequential goals often include increasing food intake every day, expanding flexibility with different food types that were previously avoided (e.g., desserts, carbohydrates), and using behavioral experiments to decrease problematic body image (e.g., reducing body checks, addressing body avoidance, mirror exposures). This process typically takes 40 weeks for patients with AN.

Research on CBT-E for AN. Approximately 10 RCTs have been conducted for CBT-E; four of these trials include individuals with AN (Atwood & Friedman, 2020). Across controlled studies, CBT-E results in large effects on improving body mass index (BMI) for people with AN (Atwood & Friedman, 2020), and improvements in ED psychopathology, though reported rates of full remission are relatively low (i.e., 16%–30% for AN; Atwood & Friedman, 2020; Byrne et al., 2017; Zeeck et al., 2018).

Summary: Treatment of Anorexia Nervosa

While CBT-E and FBT are two primary EBPIs for AN, research to improve existing treatments

is ongoing. Of note, two additional EBPIs have been identified for adults; the Maudsley model of anorexia nervosa treatment for adults and specialist supportive clinical management are also first-line approaches (Academy for Eating Disorders, 2020). Although the existing EBPIs are more effective than many alternatives, 50% or more of patients who complete these treatments may not fully recover, though a larger proportion of patients do experience symptom improvement (e.g., Atwood & Friedman, 2020; Dalle Grave et al., 2018; Lock et al., 2010). Finally, more research is needed that includes people from varied socio-demographic backgrounds.

BULIMIA NERVOSA AND BINGE EATING DISORDER

Historical Perspective on Bulimia Nervosa

Bulimia nervosa (BN) tends to be conceptualized as a more recent phenomenon than AN, with cases first identified in the mid to late 20th century (Habermas, 1989). Since the addition of BN to the *DSM-IV* in 1980, and coinciding with surging interest in behavioral and cognitive psychotherapy techniques, the intervention receiving the most attention and empirical support is CBT-E (Fairburn, 2008). Likewise, in more recent decades, a version of FBT developed for BN in children and adolescents focuses on disruption of ED behaviors with parental intervention and close monitoring (Le Grange & Lock, 2009).

Historical Perspective on Binge Eating Disorder

Though binge eating itself has been documented since ancient times (Habermas, 1989), binge eating disorder (BED) is one of the most recent additions to the *DSM*, added in 2013. Similar to BN, the primary psychological treatment investigated for BED is CBT (both clinician led and guided self-help; Peat et al., 2017), though behavioral weight loss programs have also been studied, as many individuals with BED have BMIs categorized as “overweight” or “obese”

(Dingemans & van Furth, 2012). The investigation of CBT and behavioral weight loss for treatment of BED highlights divergent areas of thinking in the field, whereby some treatments consider weight loss to be a primary treatment goal, and others focus on reduction of binge-eating episodes and related psychopathology without a focus on weight loss (Tylka et al., 2014). Psychotherapy treatment approaches that do not focus on weight loss as a treatment goal, and rather on binge reduction and improvements in ED psychopathology (e.g., CBT-E), are based upon evidence that restrictive diets are largely ineffective for weight loss in the long term and acknowledge that weight stigma may contribute to negative health outcomes in patients with BED with BMIs categorized as obese (Puhl & Suh, 2015). Given this, there are increasing calls for using weight-neutral approaches to BED treatment (e.g., Puhl & Suh, 2015; Tylka et al., 2014). Weight-neutral approaches to health counter health policies that emphasize weight loss as an explicit target for health improvement. Weight-neutral interventions emphasize that scientific evidence does not actually support the widely accepted notion that higher body weight is causally associated with poorer health outcomes, that sustainable weight loss is achievable for most people, and that weight loss improves health outcomes dramatically (Hunger et al., 2020). Thus, weight-neutral approaches to treatment focus on modifiable behaviors (e.g., eat three servings of fruit per day, walk to work twice per week).

Enhanced Cognitive Behavioral Therapy for BN and BED

Practice of CBT-E for BN and BED. The first-line treatment for adults with BN or BED include CBT and CBT-guided self-help (Academy for Eating Disorders, 2020). For those with BED, both group or individual CBT treatment is effective. Interpersonal psychotherapy (IPT) is a second-line treatment for both conditions, and group psychotherapy is a second-line treatment specific to BN (Academy for Eating Disorders, 2020). For the purposes of this brief review of psychological treatments, we will focus most

closely on CBT interventions, given they are the most well-researched treatments that are broadly applicable across conditions (Hay et al., 2009).

Treatments for BN are based upon the theory that by eating regularly, thereby reducing dieting behaviors, binge eating and compensatory behaviors will decrease (Fairburn et al., 2015). Decades of research has shown that any efforts to restrict food intake with dieting behaviors actually increases the likelihood of binge-eating episodes (Hilbert et al., 2017). Furthermore, for many patients, efforts to diet/lose weight result in more weight gain over time. As a result of restricting food quantity and limiting types of food, patients often notice urges to binge eat. Binge episodes often lead to shame and fears of weight gain, which result in the emergence of compensatory behaviors (e.g., self-induced vomiting, long periods of fasting) in a continuing cycle. Given the inverse impact of dietary restriction on binge-eating episodes, EBPI treatments for BN and BED aim to move patients toward regular, mechanical eating and weight acceptance instead of restrictive attempts to lose weight or diet. The first target in CBT treatment is thus to help the patient to eat regularly and stop all compensatory behaviors. This is accomplished by reviewing food monitoring logs kept by the patient at every session and shaping patient behavior toward eating at regular intervals throughout the day, eating enough food at each meal or snack, and resisting urges to purge. The patient's weight is tracked weekly, and the patient is guided to look for trends over time in weight changes rather than focus on small weight fluctuations. Often, the patient finds that weight remains more stable than they expected.

Beyond this first target, CBT also guides patients to cope more effectively and adaptively to cues for ED behaviors, both internal and external. Patients are taught that the context (e.g., emotional cues, interpersonal cues, environmental cues) is affecting their urges to binge and use compensatory behaviors, and that the food itself is not dangerous or unsafe. Thus, as treatment progresses, effective coping techniques are taught to the patient to respond to precipitants

of ED behaviors; patient levels of confidence and efficacy increase as patients continue to practice these techniques. Often, affect regulation techniques are especially effective for patients with BN and BED. In fact, evidence suggests that patients who are better equipped to manage negative affect, regulate emotions, and engage in self-directed behavior have a greater response to CBT interventions and a greater likelihood of remaining in remission from ED symptoms over time (Peterson et al., 2017).

For treatment of BED, CBT interventions proceed similarly as those for BN. Again, there is impetus to carefully consider pros and cons of efforts to change weight by dieting vs working toward weight acceptance. Patients who are attempting to diet by restricting the amount or types of food they eat have significant challenges with eating regularly, for instance, which is a foundational target in CBT interventions.

Research on CBT-E for BN and BED. As noted previously, CBT-E is the treatment approach for BN and BED that has accumulated the most empirical support, and CBT-E treatment outcomes for BN and BED typically show large improvements by the end of treatment (Hay et al., 2009). CBT-E treatment yields significant improvement in symptoms of binge eating, purging, and associated psychopathology, with remission rates in transdiagnostic studies of above 60% (Fairburn et al., 2015). One landmark study compared (a) wait-list control group to patients who received either (b) CBT-E treatment or (c) CBT-E treatment with additional treatment modules to treat marked mood intolerance, clinical perfectionism, low self-esteem, or interpersonal difficulties (Fairburn et al., 2009). Patients in the wait-list control group demonstrated no improvements in symptoms, but those in both CBT-E conditions exhibited substantial positive change that was maintained at follow-up 1 year or more later. Furthermore, patients who struggled with mood, perfectionism, low self-esteem, or interpersonal problems responded better to the CBT-E with additional treatment modules.

There are also effective guided self-help versions of CBT for both BN and BED, broadening the scale and range of these treatments to a greater number of affected patients. Fairburn's book meant for patients and people struggling with BN and BED, *Overcoming Binge Eating* (Fairburn, 2013), is one of the most commonly used CBT-related tools. Furthermore, research continues to emerge around technological opportunities to provide patients with real-time CBT interventions to improve coping skill generalization outside of psychotherapy sessions by smartphone applications (Juarascio et al., 2018). Thus, CBT interventions for patients with BN and BED continue to evolve in an effort to meet the demands of people who are struggling.

Finally, the same CBT treatments offered to adults are appropriate and effective with adolescents (e.g., Academy for Eating Disorders, 2020; DeBar et al., 2013), although research with youth is still in its infancy. First-line treatments for adolescents with BN include CBT and FBT, adapted for the specific ED behaviors and developmental level of the child (Academy for Eating Disorders, 2020; Atwood & Friedman, 2020). For BED, research in adolescents is limited, with some support for CBT-E delivered in either individual or group format, or CBT with guided self-help (Academy for Eating Disorders, 2020).

Of note, most samples in existing research studies are quite homogenous across socio-demographic variables, though in recent years there have been some improvements among research teams to study people in diverse groups when considering the effectiveness of interventions (e.g., Cachelin et al., 2019; Grilo et al., 2013). Still, it is yet unclear whether CBT treatment is equally effective in males, those who identify as gender nonbinary, people who are in mid to older adulthood, or those affected by food insecurity or low socioeconomic status. Treatment nuances for these and other individuals in understudied groups have not yet been clearly elucidated. Thus, research that more adequately studies the effects of EPSIs for BN and BED across more diverse samples is needed.

OTHER SPECIFIED FEEDING AND EATING DISORDER (OSFED)

Historical Perspective on OSFED and UFED

In the *DSM-5*, OSFED and unspecified feeding and eating disorder (UFED) replaced the former "eating disorder not otherwise specified" (EDNOS) in the *DSM-IV-TR* (American Psychiatric Association, 2000). There are a number of additional conditions available for diagnostic categorization under OSFED, including atypical anorexia nervosa, purging disorder, subthreshold bulimia nervosa or binge eating disorder, and night eating syndrome, which make the diagnosis more specific on the whole. Changes in the diagnostic criteria for OSFED were made to reduce the significant overrepresentation of patients meeting criteria for EDNOS (Vo et al., 2017). Gualandi et al. (2016) noted that only 30.8% of patients who met criteria for EDNOS in *DSM-IV* met criteria for OSFED in *DSM-5*, due in part to more inclusive opportunities to diagnose BN and AN. Another study demonstrated a 23.5% decrease in diagnosis of OSFED using *DSM-5* criteria compared to EDNOS using *DSM-IV* criteria (Caudle et al., 2015). Overall, the *DSM-5* seems to better represent the clinical picture in OSFED with more useful specificity than in the *DSM-IV* diagnosis of EDNOS. Furthermore, clearer phenotypes within the OSFED diagnostic umbrella will allow for more meaningful treatment research to take place (Murray & Anderson, 2015).

Though OSFED and UFED will likely allow for greater specificity in psychological treatment, it is important for psychotherapists to recognize the complexity and medical risk inherent in these conditions. Though dated, there is evidence to suggest that roughly 40% of patients with OSFED will go on to develop full-threshold AN or BN later in life (Milos et al., 2005). In a large community sample, Mustelin and colleagues (2016) discovered that only 40% of women with OSFED or UFED reached recovery after 5 years of illness, and many experienced longstanding symptoms. Psychiatric comorbidity was common as well, at similar rates

as people with full-syndrome EDs (Mustelin et al., 2016). Finally, patients with subthreshold EDs had greater medical complications compared to full-threshold EDs (Peebles et al., 2010), demonstrating that these conditions are not impervious to serious medical risk.

Psychological Treatment of OSFED

There is a general lack of research on psychotherapy outcomes for patients with OSFED, despite its relevance, clinical severity, and significant impact on patients' quality of life over time (Mustelin et al., 2016). The Academy for Eating Disorders concluded that not enough research is currently available to recommend either first-line or second-line treatments for children or adults with OSFED (Academy for Eating Disorders, 2020). Older research suggests that people with subthreshold EDs have comparable patterns of relapse and remission with those with full-threshold EDs (Grilo et al., 2007). More recent research that delineates different subtypes of OSFED suggest that patients with purging disorder have the most favorable prognosis (Smith et al., 2017), and those with atypical anorexia nervosa or subthreshold BN have similar outcomes to full-threshold EDs (Ekeröth et al., 2013).

Riesco and colleagues (2018) sought to examine the effectiveness of CBT treatment among patients with different OSFED subtypes, to better identify factors that affect psychotherapy outcome. The research sample included 176 female patients diagnosed with OSFED (82 atypical AN, 57 purging disorder, and 37 subthreshold BN). Results demonstrated very few differences on clinical and personality profiles between patients in the different diagnostic subtypes, except for those symptoms that were core to each diagnosis. Those with subthreshold BN demonstrated greater social impairment than other groups. The study found no significant differences in remission rates, dropout rates (which ranged from 36% to 50%), or therapeutic adherence across treatment groups.

Given that research on the effectiveness of psychological treatments for OSFED is still needed, most experts agree that the treatment selection

should be based on the ED that most closely resembles the OSFED presentation (Hilbert et al., 2017). For instance, if a patient meets criteria for OSFED only because they have not yet lost enough weight to meet the AN criterion of "significantly low weight," it would be most appropriate to treat the patient with an EBPI for AN. We refer the reader to earlier sections to more clearly delineate common psychological treatments for these conditions (e.g., CBT-E and FBT).

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER

Historical Perspective on ARFID

Avoidant restrictive food intake disorder (ARFID) was added to *DSM-5* in 2013. Those who meet criteria for ARFID may have been previously diagnosed with feeding disorder in infancy or early childhood, EDNOS, food avoidance emotional disorder (Higgs et al., 1989), or have food phobias (Bryant-Waugh et al., 2010); these diagnoses as a whole were understudied compared with other EDs, in part due to problems related to reliable and valid diagnosis (Bryant-Waugh et al., 2010). Compared with children who have AN or BN, youth with ARFID are more likely to be younger, male (Fisher et al., 2014), with longer duration of illness (Fisher et al., 2014; Lieberman et al., 2019).

Research on the symptoms and presentation of ARFID has suggested three behavioral phenotypes of feeding disturbance that results in food avoidance, including sensory specificity (desire to avoid foods because of sensory characteristics such as texture, color, smell, temperature, taste), lack of interest in eating or in food, or worries about aversive consequences after eating (e.g., fears of vomiting or gastrointestinal upset; American Psychiatric Association, 2013). Patients with ARFID may have one or several of these phenotypes, and understanding the specific maintaining mechanisms of ARFID is critical in treatment planning.

Historically, evidence-based treatments have focused on behavioral methods for managing

early-onset pediatric feeding difficulties, such as utilizing operant conditioning approaches for oral food refusal in infants (Thomas & Eddy, 2019). Though these behavioral treatments are effective with very young children, ARFID encompasses a broader category spanning a variety of presentations that may affect patients of all ages; thus, additional treatment strategies are required. There has not yet been enough research on psychological treatments for ARFID to endorse a specific approach (Academy for Eating Disorders, 2020), though current research on diagnosis and treatment for ARFID focuses on CBT (Thomas & Eddy, 2019) and an adaptation of FBT for ARFID (Bourne et al., 2020; Lock et al., 2019). Both these treatments are behaviorally targeted, beginning with providing psychoeducation on the maintaining mechanisms of ARFID, after which patients and families are tasked with interrupting these disordered feeding behaviors. It is critical for patients with ARFID to have full medical workup to rule out medical comorbidities that may be impacting symptoms (e.g., inflammatory bowel disease), since patients with ARFID are more likely to have a comorbid medical condition, abdominal pain and/or infection, or an anxiety disorder (Fisher et al., 2014; Lieberman et al., 2019).

Cognitive Behavior Therapy for ARFID Practice of CBT for ARFID. A recently published treatment manual for ARFID outlines the application of CBT for this population of children and adults (Thomas & Eddy, 2019). CBT for ARFID is designed to help patients increase the volume and variety of food they are consuming, and specific interventions are tailored toward the behavioral phenotypes of ARFID present for the patient (i.e., sensory specificity, fear of aversive consequences, and/or lack of interest in eating or food). There is a family-supported and an individual treatment version of CBT for ARFID, which can be chosen based on what is most appropriate for the case (e.g., considering patient age, emotional maturity, motivation). The treatment duration is 20 to 30 sessions and includes psychoeducation, developing an individualized formulation of the maintaining

mechanisms of ARFID, self-monitoring (or parent monitoring) of food intake, increasing volume of preferred foods, and increasing variety of foods. The treatment then systematically challenges the maintaining mechanisms of ARFID using exposure-based strategies (Thomas & Eddy, 2019).

Research on CBT for ARFID. There are currently no RCTs of CBT for ARFID. Results from feasibility studies of adults (15 adults aged 18–55 years) and adolescents (17 patients and families of children aged 10–17 years) provide initial promising findings, including that 80% or more of patients were rated by clinicians as much or very much improved; parents and patients also rated significant improvements on a structured clinical interview. Underweight individuals in both samples gained an average of 11 pounds, and 50% (adult sample) to 70% (adolescent sample) of patients did not meet criteria for ARFID after completing the treatment (Thomas et al., 2020, 2021). However, neither of these studies involved comparison groups, and RCTs are needed to evaluate treatment efficacy.

Family-Based Treatment for ARFID Practice of FBT for ARFID. Family-based treatment for ARFID is a parent- or caregiver-involved approach that tasks caregivers with interrupting the maintaining mechanisms of ARFID by managing the decisions about when, what, and how much their child eats and supporting them to improve nutrition and range of foods accepted. Parents are guided to stop accommodating ARFID within the household and to challenge the maintaining mechanisms of the ARFID presentation (Lock et al., 2019).

Research on FBT for ARFID. There are no RCTs for FBT for ARFID. A feasibility study of FBT-ARFID demonstrated that this treatment is acceptable to families, with moderate to large effect sizes for improving weight and clinical severity, especially for those families with greater parent self-efficacy (Lock et al., 2019).

PSYCHOTHERAPY PROCESS RESEARCH AND EATING DISORDER TREATMENTS

Psychological treatment for people across ED diagnoses requires a specialized skill set and techniques, but existing trends support certain psychotherapy process elements that elucidate how psychotherapy produces its effects (Tompkins & Swift, 2015). In a systematic review of 123 studies, high patient motivation levels and strong therapeutic alliance were associated with improved treatment response (Brauhardt et al., 2014). Furthermore, patients who responded rapidly to treatment and were in longer-duration treatments tended to respond more favorably. Importantly, future process–outcome research is needed, since this body of literature generally underrepresents minority groups or other categories less likely to seek treatment for EDs (e.g., ethnic/racial minorities, males) and assessment methods varied widely (Brauhardt et al., 2014).

CHALLENGES RELATED TO PSYCHOLOGICAL TREATMENT FOR EDs

Research Practice Gap

Addressing the research-practice gap is paramount for EDs (Kazdin et al., 2017). While a number of treatments have been designated as EBPIs, disseminating these treatments from research settings to routine clinical settings has proven to be quite difficult (Kazdin et al., 2017). Since moving toward a more competency-based model of training, organizations like the American Psychological Association Standards of Accreditation (American Psychological Association, 2015) mandate understanding and competency in evidence-based practice, yet only 6% to 35% of ED specialist clinicians adhere to evidence-based protocols (Waller, 2016).

Furthermore, ED clinicians often omit primary elements of the treatment approaches, such as in-session weight checks or patient food monitoring (Kosmerly et al., 2015; von Ranson et al., 2013). A survey of psychotherapists found the most common reason cited for using their primary treatment theoretical approach was personal

clinical experience suggesting the approach was effective; a less common reason was whether the approach had clear research support (von Ranson & Robinson, 2006). This raises concerns because when clinicians rely on clinical judgment (vs. actuarial prediction), they tend to believe there are too many exceptions in their cases to use the most effective elements of the treatment (Dawes et al., 1989).

Studies have demonstrated consistently and reliably that there are specific effects for specialized EBPIs for treating EDs, and that EBPIs are more effective than treatment as usual for EDs (Kazdin et al., 2017). Due to the considerable morbidity and mortality associated with EDs, it is critical that clinicians have the necessary skills and use EBPIs to treat them.

Access to Care for People With EDs

Regrettably, most people with EDs do not get the treatment they need (Marques et al., 2011). There is impetus to address this treatment gap and extend treatments to better reach the number of people who need care (Kazdin et al., 2017). For instance, people in racial/ethnic minority groups are less likely to be diagnosed with an ED, get referred for treatment, be screened for symptoms, or receive care (Marques et al., 2011). Research is needed to understand how to reach underserved populations and adapt treatments accordingly for diverse populations and presentations of illness.

Problems with care delivery and access for people with EDs is multifaceted and includes issues related to treatment funding, lack of standards of care, and provider training (Kaye & Bulik, 2021). Care for EDs may be delivered in multiple treatment settings ranging from full-time hospitalization to outpatient treatment, which can be confusing for patients and families to navigate. Indeed, while patients should receive care in the least restrictive environment that is feasible, the medical and psychiatric complications of EDs may result in the need for higher levels of care, including medical hospitalizations, residential treatment, psychiatric admissions, or intensive outpatient programs such as partial

hospital or day hospital. Guidelines, such as the American Psychiatric Association Practice Guidelines (American Psychiatric Association, 2006), are available to determine the most appropriate level of care given clinical characteristics of the patient. Such guidelines recommend assessment of level of care based on medical and psychiatric stability, suicide risk, motivation, and the ability to reduce ED behaviors in less restrictive environments. For instance, a severely malnourished adult patient who is at high risk of refeeding syndrome may require medical stabilization followed by intensive treatment (e.g., residential or partial hospital program) until they are able to eat consistently and independently and medical complications resolve; this patient may not respond to outpatient psychological treatment until after receiving this higher-level-of-care treatment that renourishes the brain. There are calls for mandated standards of care in ED treatment, improved access for under- or uninsured individuals, and reinvigoration of academic ED programs and ED research funding to improve treatments in an effort to improve prognosis and reduce the substantial public health burden (Kaye & Bulik, 2021).

Other outreach models may alleviate treatment gaps by improving provider training and expanding the number of providers who can deliver effective psychological treatments (Kazdin et al., 2017). Web-based training is one approach that is gaining traction in the literature as a viable and effective way to train therapists to deliver care, such as the CBT-E training platform used by the Irish Health Service Executive (Fairburn et al., 2017). The virtual training includes a roughly 9-hour course that contains practical description of the treatment, videos and handouts, learning exercises, illustrations, assessments/feedback provided throughout, and a library with supplementary information on using CBT-E with specialized populations and adolescents. Results showed that the training was acceptable, feasible (84% completed it over 20 weeks), and led to a significant increase in psychotherapist clinical competence after the training (Fairburn et al., 2017). Other possibilities to increase the number of specialist ED clinicians include train-the-trainer

models (Greif et al., 2015), web supervision (Fairburn & Wilson, 2013), refresher courses and/or continuing education to address therapist drift (Fairburn & Wilson, 2013; Kazdin et al., 2017; Waller, 2009), and continued efforts to offer guided self-help options for patients at risk.

TRAINING IN PSYCHOLOGICAL TREATMENT FOR EDs

A variety of ways are available for therapists to achieve clinical competence when working with people with EDs. One study suggested that most (96%) psychotherapists who identified themselves as specialists in treating EDs had training via workshops, self-study, informal supervision, formal clinical training, and formal supervision (von Ranson & Robinson, 2006). Most therapists are trained by a workshop or presentation followed by specialized clinical supervision, all while following a treatment manual. Evidence suggests that specialized clinical supervision is especially important in obtaining competencies for ED treatment (Herschell et al., 2010). If psychotherapists are seeking professional licensure in the United States, they should also consider jurisdictional requirements; for instance, in some states the treatment of people with EDs is a “specialty” designation under a clinical psychology license, and the applicant must document what steps they took to gain competence in this area.

Certification as an ED specialist is also available through the International Association of Eating Disorder Professionals. This process includes didactic coursework, continuing education specific to EDs, a minimum of 2,500 supervised hours (over the course of at least 2 years, provided by a certified supervisor/consultant), an examination, letters of recommendation from ED professionals, and a written case study. Another designation is a Fellow of the Academy for Eating Disorders, which distinguishes professionals with a national or international reputation for contribution to the field of EDs via research-based scholarship, literature for lay audiences, clinical service, leadership, and/or advocacy.

Finally, EBPI-specific certification and training is available. Readers interested in CBT-E certification can access this certification process via an online training program (<https://www.cbte.co/for-professionals/training-in-cbt-e/>) designed to be used alongside relevant sections from the treatment manual (Fairburn, 2008). For licensed mental health providers interested in FBT certification, a certification process is available from the Training Institute for Child and Adolescent Eating Disorders (<http://train2treat4ed.com/training>).

SUMMARY AND RECOMMENDATIONS

Much is left to learn about EDs, including identification of specific biological, behavioral, genetic, and psychological targets for intervention (Kaye & Bulik, 2021). Furthermore, well-designed studies are needed to better evaluate efficacy and effectiveness and compare different intervention approaches, since many forms of treatment have been studied in relatively few trials. It is notable that for some EDs, especially AN, rates of full remission following EBPI interventions remain low, and it has been argued that there have been few advances in treatment over the past 20 years (Bulik, 2021). Further, many patients receive ED treatment in higher levels of care (e.g., residential treatment), while most EBPIs are studied in outpatient settings. Innovation is needed to improve existing treatments, and funding support is necessary to support research teams in testing these interventions across multiple levels of care (Bulik, 2021). Clearly, research is also needed to investigate the effectiveness of EBPI treatments in more diverse samples and identify more culturally sensitive interventions, as much of the research on EDs is dominated by samples of young White females.

There is also a need to operationalize the definition of “recovery” and identify clear treatment targets. Indeed, there is no standard definition of positive treatment outcome for EDs (Bardone-Cone et al., 2018). To complicate this problem further, there have been concerns with the

psychometric properties of some commonly used treatment outcome instruments (Thomas et al., 2014). As a field, it is urgent to disseminate psychometrically sound assessment instruments and to operationalize an evidence-based definition of positive treatment outcomes (Bardone-Cone et al., 2018).

Access to evidence-based treatment for EDs is poor, and development of scalable opportunities to disseminate EBPI treatments to providers is a promising strategy to address this gap. Indeed, while EDs are complex disorders to treat, patients receiving competent, evidence-based care as early in symptom trajectory as possible can fully recover.

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