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CHILD PSYCHIATRY

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Glen Elliott, MD, PhD

Editor-in-Chief

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Learning Objectives

After reading these articles, you should be able to:

1. Describe some of the ways to assess and treat binge eating disorder in children and adolescents
2. Discuss how family based treatment is used to help children and adolescents recover from eating disorders.
3. Summarize some of the current findings in the literature regarding psychiatric treatment.

Taking Back Control in Binge Eating Disorder

Sara Weekly, MD, child and adolescent psychiatrist. Clinical assistant professor, New York University School of Medicine, New York, NY.

Dr. Weekly has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Confined to the appendix in previous editions of the Diagnostic and Statistical Manual (DSM), binge eating disorder (BED) took a leap into the spotlight with its inclusion as an official diagnosis in 2013's DSM-5. It is one of the more controversial of DSM-5 disorders, with some claiming that BED

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In Summary

- According to DSM-5, binge eating disorder (BED), which became an official diagnosis in 2013, is very similar to bulimia nervosa, except there is no purging behavior.
- Children and adolescents brought in for anxiety and depression should be screened for eating disorders by asking about their eating habits and their relationship to food.
- Treatments for BED include psychotherapy, medication, nutrition education, and complementary health approaches.

Q&A With the Expert

Eating Disorders: Assessment and Treatment

James Lock, MD

Professor of psychiatry and pediatrics at Stanford University School of Medicine

Dr. Lock has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CCPR: Why did you specialize in eating disorders?

Dr. Lock: On our child psychiatry inpatient unit, among the kids with eating disorders, I saw that half or more were medically ill as a result of malnutrition or other behavioral problems associated with eating disorders that led to problems with electrolytes or blood pressures. I saw these wonderful young people—mostly girls, but boys too—who were amazing kids in many ways, but terribly lost in the confused thinking and values and behaviors that we know as eating disorders. At that time, we were completely taking care of things on an inpatient level, because we didn't have an outpatient program.

CCPR: How common are anorexia and bulimia in young people?

Dr. Lock: Anorexia nervosa (AN) is actually a comparatively rare one—a little under 1% of adolescent females—but then you add bulimia, which is 2%–3%, and then you add binge eating, which is another 3%–4%, and you get to numbers and percentages that are rather high at 7%–8%, maybe even higher if you begin to count dysfunctional eating that leads to obesity that isn't necessarily binge eating but close.

CCPR: What is typical age of onset?

Dr. Lock: For AN it's about age 14. Bulimia has a slightly later onset. The behaviors might start at 16, but by 18, 19 you get full-fledged bulimia.



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Taking Back Control in Binge Eating Disorder Continued from page 1

inappropriately turns overeating and obesity into a psychiatric disorder. BED's supporters counter that the diagnosis is reliable and causes real psychological distress. Regardless of which side of the debate you favor, the likelihood of encountering patients who struggle with binge eating is high. In this article, I review how to diagnose BED and introduce strategies for helping kids and teens take back control over their consumption.

EDITORIAL INFORMATION

Publisher: Daniel Carlat, MD

Editor-in-Chief: Glen Elliott, MD, PhD, is the former Director of Child and Adolescent Psychiatry and Emeritus Professor of Clinical Psychiatry at the University of California San Francisco, CA.

Deputy Editor: Talia Puzantian, PharmD, BCPP is associate professor at the Keck Graduate Institute School of Pharmacy in Claremont, CA

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This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists, and other health care professionals, with an interest in the diagnosis and treatment of psychiatric disorders.

Prevalence and correlates

The DSM-5 criteria for BED are essentially the same as bulimia but without purging behavior (American Psychiatric Association, 2013). Specifically:

- Patients have recurrent binge eating episodes (ie, episodes of eating significantly more food in a short period of time than most people would eat) occurring an average of once a week for at least three months.
- Episodes are marked by lack of control over eating and may be characterized by rapid eating, eating while not hungry, or eating alone.
- Binging is associated with feelings of guilt, embarrassment, or disgust.
- There is no compensatory purging/weight loss behavior, such as vomiting, laxative use, or obsessive exercise.

According to the WHO World Mental Health Surveys (Kessler R et al, *Biol Psychiatry* 2013;73(9):904-914), BED is the most common specific eating disorder, with a lifetime prevalence of 1.9%. It is roughly twice as common as bulimia nervosa (BN), which in turn is more common than anorexia. BED tends to start a little later in life than other eating disorders, with a median age of onset of 19 years. One striking thing about BED as opposed to other eating disorders is that it occurs relatively frequently in males, with a female to male ratio of about 3:1. As is true for BN, patients with BED are highly likely to have another psychiatric disorder, with an 88% chance of comorbidity in adolescents. The most common comorbid diagnoses are anxiety disorders (especially PTSD and separation anxiety disorder), bipolar disorder, ADHD, and oppositional defiant disorder.

Assessment and diagnosis

Jayden is a 15-year-old boy who has been slightly overweight since he was a toddler. His parents and older brother are also overweight, and they will sometimes make jokes about the family's weight issues and Jayden's

appearance. Their extended family often gathers for Sunday meals, and Jayden has always enjoyed partaking in the festivities. Over the past six months, Jayden has started returning to the kitchen on Sunday evenings and again on Mondays shortly after dinner and eating portions of leftovers in secret. For the first few bites, he enjoys the food, but then, he says he feels like he cannot stop until the entire pan or container is finished. He is embarrassed by his behavior and feels miserable afterwards. He makes excuses about the missing food, saying the dog ate it or that he dropped it on the floor and had to throw it away. Over the past few weeks, he has also begun purchasing food to eat on other nights alone in his room. He sneaks out before his family wakes up in the morning to bury the evidence in the trash. His parents have noticed that he seems more withdrawn and anxious than usual, and the school called to report he has been refusing to change for gym class.

Consistent with Jayden's case, bingeing behaviors often go unreported, and they are rarely the primary reason for consultation. Instead, parents may bring in their child for a comorbid condition such as anxiety or depression. Therefore, it's important to ask specific questions about eating disorders. Also, beware of making assumptions regarding the association between BED and obesity; bingeing can occur in patients at any weight. I will also ask specific questions about the patient's eating habits and relationship to food (see the Suggestions for Evaluating Binge Eating Disorder table on page 3 for a handy list of questions).

If your initial screen makes you suspect a binge pattern, the next steps will be to characterize the frequency, intensity, and duration of the bingeing behavior, as well as the quality of your patient's thoughts around eating.

Most children and teens are frustrated with their inability to control their eating habits. Validate that frustration with empathic and normalizing statements like "a lot of kids have a tough time with controlling their eating, and it's really frustrating." It's important to

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Taking Back Control in Binge Eating Disorder Continued from page 2

Suggestions for Evaluating Binge Eating Disorder	
Questions	Other Items to Cover
<ul style="list-style-type: none"> • Do you ever eat in secret? • Have you ever made yourself sick because you felt you ate too much? • Do you ever feel like you can't control or stop eating? • Would you say food dominates your life? • Are you satisfied with how much and what you eat? • In what ways does your weight or body shape affect how you feel about yourself? • How has your weight fluctuated over the past six months? 	<ul style="list-style-type: none"> • Consider taking a 24-hour diet recall from both child and parents. • Always ask about compensatory measures such as weight loss supplements, diet pills, purging, and exercise. • Don't forget to ask about family history of eating disorders, as well as personal history of other eating disordered behaviors in the past.

Modified from the Eating Disorders Screen for Primary Care and SCOFF screening tools (Cotton M et al, *J Gen Intern Med* 2003;18(1):53-56)

ask what strategies they may have tried in the past and what that experience was like for them.

Motivational interviewing

If patients are reluctant to engage, I'll often use motivational interviewing techniques to move towards treatment planning. I start by asking open-ended questions about the effects of binge eating: "Do you spend a lot of money on food?" "Does your eating make it stressful or awkward to hang out with friends?" "Does anyone tease you about your eating habits—or do you worry that they might?" "Do you ever fight with your parents about your eating?" "What do you think you might be missing out on because of your bingeing?" I try to focus on what patients find most concerning or impairing about their thoughts and behaviors.

Once we've agreed that there are some negative consequences, I'll explore the patients' degree of motivation to deal with them. For example, "How much of a problem is it that you've been spending an extra \$20 a week on your eating?" "How important is it to you to stop?" I take an empathetic, non-confrontational stance with the goal of helping my patients imagine a happier, healthier future self that they feel empowered to work towards.

Jayden's parents brought him to his pediatrician, who referred him to a child psychiatrist for evaluation. He was diagnosed with binge eating disorder, and over the course of the initial interview he

agreed that it was a significant problem affecting his relationships and causing him to isolate more and more. He expressed a high motivation to change and willingness to meet with a therapist to learn more.

Treatment of BED psychotherapy

If you are lucky enough to have a local therapist who specializes in eating disorders, that would be ideal. Otherwise, you can refer to a general child therapist or provide the therapy yourself. In some underserved areas, patients may not be able to find specialized treatment. There are various do-it-yourself resources—see the table below for examples of mobile apps and workbooks. With these options, your role is to encourage adherence, set goals, review concepts, and answer questions that come up during your patient's work at home.

Cognitive behavioral therapy

CBT currently has the strongest evidence base among psychotherapeutic

options for treating BED, although interpersonal therapy (IPT) and dialectical behavioral therapy (DBT) have shown promise in recent studies (Iacovino J, et al, *Curr Psychiatry Rep* 2012;14(4):432-446). If you do not have specific training in this area but would like to provide treatment yourself, I recommend reading through several therapist treatment manuals and pulling exercises and concepts that fit with your style and patient population (see the Therapist Treatment Manuals for Eating Disorders table on page 5 for examples).

CBT begins with an educational/exploratory phase to help kids understand the factors that lead to bingeing. Common triggers include the following: 1. Overly rigid "rules" about eating and fasting, rules which patients are likely to break, leading to binges; 2. Chemical disinhibitors (eg, alcohol); 3. Emotional disinhibitors (eg, frustration, academic deadlines, social stress); 4. Situational cues (eg, candy bowls or buffets). Food diaries can help identify where, when, and in what emotional context the bingeing occurs.

Once you have this information, work with your patient to create a plan for regular eating, including a balanced meal or snack every 3-5 hours. Develop a list of strategies that the child can use to avert binge impulses. These might include activities that are incompatible with eating (eg, finger painting, going for a walk, playing an instrument), self-talk and affirmations that reinforce the patient's sense of control (eg, "This craving is temporary," "I can choose to leave the kitchen," etc), and preventing situational triggers (eg, ordering a la carte at buffet restaurants, starting school projects earlier to avoid stressful all-nighters).

In addition to these therapeutic strategies, consider adding exposure exercises with "forbidden foods" to help take the power out of these items. For kids who identify bullying or family conflict as triggers, you can also work on communication skills and assertiveness.

The last phase of treatment will focus on relapse prevention. Patients with BED often struggle with all-or-

Self-Help Resources for Patients With Eating Disorders	
Mobile Apps	Workbooks/Authors
Recovery Record	Hope, Help and Healing for Eating Disorders/Jantz
Kissy Project	Overcoming Binge Eating/Fairburn
Rise Up + Recover	Bulimia: A Guide to Recovery/Hall and Cohn

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Expert Interview
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CCPR: Are the motivators different in young people than adults that develop anorexia and bulimia?

Dr. Lock: Not really. The motivators—being good, being perfect, being in control and serene—are the kinds of things that underlie the kind of psychological make-up of people with AN. We talk about AN being ego-syntonic, meaning patients actually like their illness because they get something good from it. There is hardly any variation in AN across cultures and ages: People with AN have the same types of personality characteristics. They are perfectionistic; they're driven; they're anxious people. AN patients aren't working on their appearance; they diet not for others but for themselves. They are not really motivated by attracting a lot of people to them physically. In fact, most kids with AN are pretty socially and sexually avoidant. That's not what's pulling them into the process.

CCPR: So there is a definite personality type to keep in mind for anorexia. Are there different behavioral tendencies for kids who develop bulimia?

Dr. Lock: Yes. Bulimia is ego-dystonic. People are ashamed of their behaviors; they're ashamed of their binging; they're ashamed of their purging generally. And so there's a very different kind of mindset. Bulimic patients typically do care a lot about wanting to be attractive to other people and diet to try and do that. They do want to engage the attention of others and are frustrated by their attempts to create a body that will attract people. Now, some of them drift all the way into AN, and some anorexics evolve into becoming bulimics over time. But, in their true forms, one way to put it is that anorexic patients have a sort of pride in accomplishment, and bulimics have a shame of failing to diet sufficiently. Although these illnesses come from different psychological places, clinicians should be aware of the same types of behavioral signs.

CCPR: And what are some behavioral clues for eating disorders?

Dr. Lock: Pay attention to any kid in your office who is starting to diet and clearly doesn't need to be, or who starts losing significant amounts of weight—that should be a cautionary flag. If by history or presentation you have a young person who is high-performing, competitive, and perfectionist, be worried that this could be a place where they could start applying that same kind of thinking. Also, kids who are over-exercising, meaning that they are exercising more than they need to be either for their sport or for their health, and with a design of losing weight, that's a warning sign.

CCPR: That's good to know. Where do parents fit into this? Are they usually in sync as to what's going on?

Dr. Lock: Yes, most of the time they will have noticed a weight loss, especially with the younger ages. I'd say what usually happens is that the caregivers will be concerned and either contact the pediatrician for a specific appointment or bring up the topic during a well or sick visit. So, usually these kids are seen at some point when things are starting.

CCPR: So it's the pediatrician who usually detects the problem and acts on it?

Dr. Lock: Well, it's interesting that you say that, because most psychology training programs don't provide adequate experience and training for the detection and treatment of eating disorders. That in itself is astonishing, because it's so common. And, if the psychiatrists and psychologists aren't learning about it, you can be sure that the pediatricians aren't learning either. The pediatrician often says, "Come back in 3 months." But, 3 months later is too late. The thing they don't understand is that, once these kids get these behaviors, they may start off sort of slowly over a 5- or 6-month period, when they reach a crescendo, which usually is about when the parents are really aware that there's a problem. A weight loss of 10 to 15, even 20 pounds over a 2- to 3-month period is common (very rapid, in other words). So, between the time they see the pediatrician and the 3-month return visit, they're often already in the hospital.

CCPR: That's very concerning. So for some of these patients, you don't end up seeing them until things may have become dire?

Dr. Lock: Right. We still get referrals where parents say, "Well, we went to the pediatrician. She lost 10 or 12 pounds. She was dieting extensively and over-exercising, and we were told, 'This is a phase, she'll outgrow it.' Well, she didn't outgrow it, and now she's in the hospital with a heart rate of 37."

CCPR: So, going back to that initial clinic visit. What needs to happen?

Dr. Lock: The patient needs to receive good, sound advice: You need to eat more, you need to exercise less, the emotional and physical effects of proper nutrition, etc. And the pediatrician or other clinician should say, "We're going to schedule an earlier visit to make sure that the advice you just got has led to a change." There will be some kids for whom it is a phase; when corrected, they go back to normal eating and that's fine and their weights normalize. The problem is, most often, that isn't what happens.

CCPR: Let's shift and talk about treatment. How did you create your current outpatient intervention program?

Dr. Lock: When I first began working with kids with AN, it was in an inpatient setting, where the kids often stayed for 3 to 4 months. They were admitted and discharged mostly weight restored and eating pretty much independently. They would go home, but many of them didn't do well. So, it was very confusing and not very rewarding to have kids return to the hospital in just as bad shape or worse a few months after we'd been treating them. What we discovered was that since inpatient wasn't working all that well, let's try a better outpatient approach. And we discovered this stunning—truly shocking fact: We didn't know anything about how to treat outpatient AN. There were no evidence-based treatments, which is why we developed the family-based treatment (FBT) approach.

We still get referrals where parents say, "Well, we went to the pediatrician. She lost 10 or 12 pounds. She was dieting extensively and over-exercising, and we were told, 'This is a phase, she'll outgrow it.' Well, she didn't outgrow it, and now she's in the hospital with a heart rate of 37."

James Lock, MD

Taking Back Control in Binge Eating Disorder
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Therapist Treatment Manuals for Eating Disorders	
Title	Author
Cognitive Behavior Therapy and Eating Disorders	Christopher G. Fairburn (The Guilford Press: New York, NY; 2008)
Cognitive Behavioral Therapy for Eating Disorders: A Comprehensive Treatment Guide	Glenn Waller et al (Cambridge University Press: New York, NY; 2007)
Eating Disorders: Cognitive Behaviour Therapy With Children and Young People	Simon G. Gowers and Lynne Green (Routledge: London, England; 2009)

nothing thinking, and it can be helpful to anticipate and normalize setbacks as a natural part of the recovery process.

Integrative treatments

Nutritional strategies

A consultation from a nutritionist who has experience working with eating disorders can be very helpful. Nutritionists can help children and their parents learn how to develop balanced meal plans. Punitive or restrictive meal plans should be avoided. Specifically, behavioral weight loss programs that focus primarily on calorie and exercise goals are generally not recommended for kids and teens with BED.

Complementary health approaches

Mindfulness, yoga, and meditation have been shown to be effective for patients with eating disorders, and there are preliminary studies that show promise in BED specifically (Kristelier, JL and Wolever, RQ, *Eating Disorders* 2011;19(1):49–61) (McIver S et al, *Complement Ther Med* 2009; 17(4):196–202). These methods attempt to reconnect patients’ thoughts to their physical bodies, encouraging more attunement to natural sensations and cues and decreasing baseline levels of anxiety and distress.

Psychopharmacology

Although no medication has been FDA approved for BED in a pediatric population, several classes of medications have shown promising results (McElroy S et al, *Ther Clin Risk Manag* 2012;8:219–241).

Antidepressants

SSRIs in general appear to help with bingeing, eating-related psychopathology, and depressive symptoms, although fluoxetine is the only medication currently FDA approved for BN in adults. Multiple meta-analyses have shown a reduction in BED symptoms and less frequent relapse with antidepressants, with the strongest evidence available for SSRIs. However, SNRIs such as duloxetine (Cymbalta) and venlafaxine (Effexor) as well as bupropion (Wellbutrin) have also shown promise in reducing these symptoms, and bupropion may have the additional benefit of weight loss/mild appetite suppression (Goracci A et al, *J Addict Med* 2015;9:1–19). However, bupropion is contraindicated in patients who are actively purging, and I take care to specifically discuss its effect on lowering the seizure threshold with any patient that I suspect may be vomiting or abusing alcohol.

Anticonvulsants

After observations that bingeing behavior seemed to stop with phenytoin use, antiepileptic medications became a target of study. Useful in comorbid mood disorders and known for its promotion of weight loss, topiramate (Topamax) has been tested and is effective for weight loss and decreasing binge frequency in adults (Berkman ND and Brownley KA, *Comparative Effectiveness Reviews* 2015;160. <http://europepmc.org/books/NBK338300>). Zonisamide (Zonegran) is also effective in BED in adults, but many people dropped out of treatment in these studies because of side effects such as drowsiness, dizziness, and loss of coordination.

Stimulants

Recently FDA approved for the treatment of BED, lisdexamfetamine (Vyvanse) has been the topic of fervent discussion (see *TCPR*, June 2015). There is no question that the medication is effective for BED; but, as with all stimulants, there is a concern about substance abuse and diversion. Atomoxetine (Strattera) also has shown some preliminary evidence for efficacy in symptoms, as have stimulant medications other than lisdexamfetamine.

Jayden was referred to a local cognitive behavioral therapist, who saw him weekly for several months. Over the course of the therapy, it became clear that he viewed himself as weak and unable to say no to food. The therapist reframed these as irrational automatic

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Effective Treatments for Binge Eating Disorder				
	SSRIs	Topiramate (Topamax)	Lisdexamfetamine (Vyvanse)	CBT
Abstinence from binges	1.7x higher than placebo	2x higher than placebo	2.6x higher than placebo	4.2x higher than waitlist (placebo)
Eating-related psychopathology	Improved	Improved	Improved	Improved
Weight loss	No significant change	Mean of 4.5 kg lost	Mean of 4.9 kg ² lost	No significant change
General depression	Reduction in HAM-D/ HDRS of 1.98	No significant change	No significant change	No significant change
Major side effects/ drawbacks	GI upset, headache, sleep disturbance	Sleep disturbance, headache, sedation, sympathetic activation	Insomnia, headache, sympathetic activation	Cost, travel, time investment

¹Berkman ND and Brownley KA, *Comparative Effectiveness Reviews* 2015;160: <http://europepmc.org/books/NBK338300>. ²Value not provided by Berkman; taken from an alternative meta-analysis by Citrome L, *Int Journal of Clin Practice* 2015;69:410–421.

Research Updates
IN PSYCHIATRY

Bret A. Moore, Psy.D, ABPP

Dr. Moore has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

ADHD

Meds for ADHD Not Working? Add CBT

(Sprich S et al, *J Child Psychol Psychiatry* 2016;doi:10.1111/jcpp.12549 [Epub ahead of print])

Medication is an effective and necessary treatment for many adolescents struggling with ADHD. Unfortunately, even when patients and parents report significant relief from meds, symptoms persist, which can lead to ongoing problems at school, at home, and with peers. That's why psychosocial interventions are an important part of any treatment plan for adolescents with ADHD. Given the need for effective non-medication treatments, researchers looked at a modified form of cognitive behavior therapy (CBT) specifically for adolescents with ADHD who were stable and doing well on meds but still had troubling symptoms.

A group of 46 adolescents between the ages of 14 through 18 with ADHD who had responded only partially to medication were randomly assigned to either medication plus CBT (24 subjects) or medication alone (22 subjects). CBT consisted of 12 weekly sessions teaching skills related to self-regulation, procrastination, negative thinking, and relapse prevention. The patients who were assigned to medication alone were allowed to cross over to the CBT arm of the study after 4 months; 15 of them did so. All patients were assessed blindly at baseline, 4 months, and 8 months on three outcomes: parent and child ratings of symptom severity (ADHD Current Symptom Scale) and overall distress (Clinical Global Impression Scale).

At the end of treatment, CBT clearly added value. Compared to no treatment,

average scores on parent, adolescent, and distress ratings dropped by 10.93, 5.24, and 1.17 points, respectively. Researchers also used a 30% reduction on the ADHD rating scale to identify "treatment responders." They found that, per the parents' view, 50% of adolescents improved.

CCPR's Take: Adolescents already on ADHD medications, and doing relatively well, can likely do even better with CBT.

AUTISM

Risperidone Leads to Serious Metabolic Problems in Autistic Children

(Scahill L et al, *J Am Acad Adolesc Psychiatry* 2016;55(5):415-423)

The metabolic effects of atypical antipsychotics in children are well known, and carefully weighing the risk-benefit ratio of their use is a difficult ordeal for both parents and clinicians. The reality is that the use of these meds is necessary for some children, particularly those dealing with an autism spectrum disorder with serious behavioral problems. Risperidone is the most commonly used atypical for this purpose. To better understand its impact on weight and metabolic processes, researchers tracked multiple metabolic risk factors in autistic children ages 4-13.

As part of a larger 24-week randomized trial, 97 autistic children assigned to risperidone only or risperidone plus parent training were monitored for changes in appetite, weight, and markers associated with metabolic syndrome (waistline, glucose, lipids, hypertension). Children received twice-daily dosing of risperidone. Dosing was based on weight and ranged from 1.75 mg/day for children less than 20 kg/44

lbs and 3.5 mg/day for those heavier than 45 kg/99 lbs.

The results were striking. After 6 months of treatment, the children's weight increased by an average of 5.4 kg/11.9 lbs, waist size increased by slightly more than 6 cm/2.4 inches, and the percentage of kids with a normal BMI (body mass index) decreased from 60.8% to 29.4%. A number of laboratory measures of health also worsened, including increases on glucose and liver enzymes. The number of kids with metabolic syndrome grew from 7 to 19 by 4 months. The effect of risperidone on weight was greatest for children who reported being hungrier during the first 8 weeks.

CCPR's Take: While this study did not include a placebo group to act as a control, the dramatic metabolic effects of risperidone on children are well known from other research. The authors make specific suggestions about labs to monitor before and during treatment (see bulleted list below). Unfortunately, there are no suggestions about how to minimize the potential negative effects, nor do there appear to be any other interventions that are quite as effective for agitation in autism as atypical antipsychotics. Still, studies such as this one encourage us to try out as many alternatives as possible.

The authors of the article recommend measuring the following before starting children on atypical antipsychotics:

- Appetite¹
- Weight¹
- Waist circumference¹
- Liver function²
- Lipids²
- Glucose²

¹Monitor early and regularly during treatment. ²Monitor periodically.

Expert Interview

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CCPR: And how does family-based treatment work?

Dr. Lock: The goal of FBT is to teach parents how to help their children with AN develop healthy eating and weight habits. In the first phase (sessions 1-8), the focus is on the eating disorder and includes a family meal. We make sure the parents realize they are not responsible for causing the disorder and we compliment them on the positive aspects of their parenting. Families consult with a therapist and figure out how best to re-feed their child with AN. In phase 2 (sessions 9-14),

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CME Post-Test

To earn CME or CE credit, you must read the articles and log on to www.TheCarlatChildReport.com to take the post-test. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by May 31, 2017. As a subscriber to *CCPR*, you already have a username and password to log onto www.TheCarlatChildReport.com. To obtain your username and password, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning Objectives are listed on page 1.

1. What is the ratio of females to males with binge eating disorder? (Learning Objective #1)
 a. 2:1 b. 3:1 c. 5:1 d. 10:1
2. Phase 3 of the family-based treatment approach to treating children and adolescents with eating disorders is characterized by which theme? (LO #2)
 a. Educating children and parents about relapse warning behaviors
 b. Affirming that parents are not responsible for causing their child's eating disorder
 c. Teaching parents how to give control of eating back to the adolescent
 d. Helping children establish and maintain a positive long-term relationship with their parents
3. Which of the following medications should not be used to treat BED patients who are actively purging? (LO #1)
 a. Duloxetine b. Fluoxetine c. Topiramate d. Bupropion
4. The typical age of onset for anorexia nervosa is slightly later than bulimia or BED. (LO #2)
 a. True b. False
5. According to a recent study, adolescents with ADHD who received ADHD-specific cognitive behavior therapy in addition to medication self-reported a _____ improvement in symptom severity. (LO #3)
 a. 25% b. 43% c. 58% d. 76%

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Expert Interview

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once weight restoration is nearing completion, parents are taught how to give control of eating back to the adolescent. The third phase (sessions 15–18) starts once the patient has achieved a normal weight and does not display any more anorexic symptoms. The theme in this phase is to help the adolescent establish and maintain a positive long-term relationship with their parents.

CCPR: Is family-based treatment widely offered?

Dr. Lock: Unfortunately, it depends on where patients live and what resources the family can access. They may hear that “the best evidence-based treatment is family-based therapy,” but if they live in rural Montana and there is not a single trained person available to teach that treatment, then that’s a problem. One way we’re trying to address that challenge is to train professionals using technology. We are developing an online version of training that we’re piloting and actually testing in a randomized global clinical trial right now. We hope that the results will tell us whether this strategy will be useful for dissemination.

CCPR: And what about online training for families as opposed to professionals? Is that feasible?

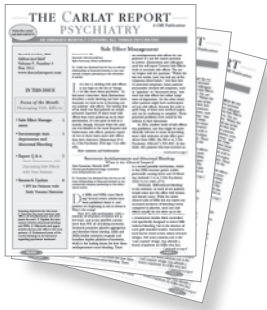
Dr. Lock: Yes, in fact we just completed a pilot study that taught guided self-help to parents. They essentially received the same or very similar training online that we would give to professionals, along with a weekly 30-minute therapist-guided discussion. Although you can’t meet with the whole family as in traditional family therapy, it looks like the kids whose families participated in the study did relatively well. It wasn’t a randomized clinical trial, but it gives a sense that guided self-help versions of family therapy might indeed be feasible for some patients.

CCPR: Have you had any success applying technology like phone apps and such?

Dr. Lock: We have a project right now that uses phone apps for binge eating and bulimia; it promotes self-monitoring, which is really the key piece of behavioral therapy for these conditions. Using that app alone, about 30% of patients improved their eating-related psychopathology. That’s encouraging, and we are refining the app so that it’s even more attractive to users.

CCPR: That’s good to hear. Thank you for your time, Dr. Lock.

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This Issue's Focus:
Eating Disorders in Children and Adolescents

Next Time in *The Carlat Child Psychiatry Report*: Mood Dysregulation Disorders in Children and Adolescents

Taking Back Control in Binge Eating Disorder

Continued from page 5

thoughts and pointed out that in other areas of his life, such as practicing the guitar, Jayden had strong willpower. With journaling and at-home exercises, Jayden was able to identify a list of key triggers for bingeing, and he started practicing new ways of dealing with them. For example, he stopped skipping breakfast when he was feeling guilty about eating, and he started playing soccer with his cousins after their Sunday dinners. When he started to binge, his mother initially stepped in to help him confront his automatic thoughts; but, over time, Jayden felt increasingly confident in his ability to do this for himself.

CCPR VERDICT:

Now that BED has been bumped into the big leagues, it seems reasonable to hope that our field will become more vigilant about screening for symptoms and recommending appropriate interventions. Remember, many of our young patients may not imagine that their bingeing—no matter how distressing or impairing—could be a treatable disorder, so we have to specifically ask about these behaviors. By educating our patients and connecting them to appropriate care, we can change these children's relationships to food for life.

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