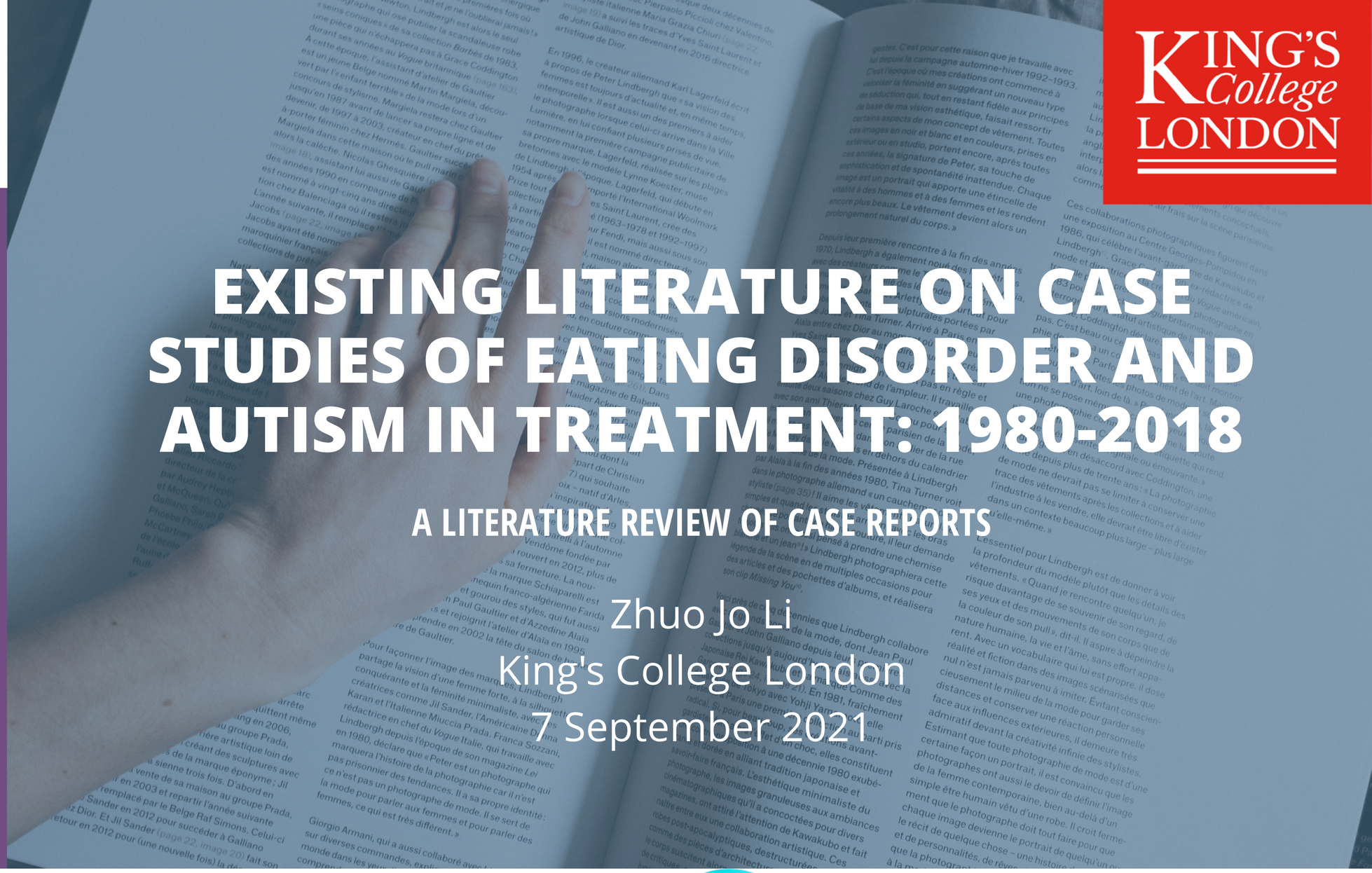
PEACE

Pathway for Eating disorders and Autism developed from Clinical Experience

KING'S College LONDON



EXISTING LITERATURE ON CASE STUDIES OF EATING DISORDER AND AUTISM IN TREATMENT: 1980-2018

A LITERATURE REVIEW OF CASE REPORTS

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BACKGROUND

- A systematic review to identify adapted interventions for the comorbidity
- PEACE Pathway: the only identified adapted pathway for patients with ED and ASC
- **Case studies (1980 ~ 2018): describing cases in treatment**

CASE STUDY 1

STIVER & DOBBINS, 1980
UNITED STATES

CASE

S, a 12-year-old autistic girl

- Placed in a public school programme for severely emotionally disturbed children
- Eating patterns deteriorated rapidly in a 3-month period:
  - Interest in other people's physical stature; increased interest in dieting
  - Mother on a diet; readily spoke about dieting at home
  - 3rd month: refused to take certain foods in school, saying she could no longer eat them because she did not like the way they tasted.
  - Stated that she could not eat because food would make her sick
  - By the end of 3rd month: became physically ill and vomited at the sight of some foods and refused to eat others
  - Noticeable weight loss; no other medical ailments

INTERVENTION

By the teaching staff and school consultant; behavioural

Basic behavioural techniques:

- Use desserts and desired activities as reinforcing contingencies
  - Effective for about 1 week, after which S began to refuse to eat most dishes (would attempt to eat with prompting, but would often gag and spit up. Large quantities of milk or water were used to help her wash down small amounts of food)
- Mother was told to eliminate references to her diet at home
- Environmental factors evaluated: previously S was in a self-contained lunch program. Teacher recalled that preceding the onset of the eating problems S had expressed a desire to eat lunch in the school cafeteria with other children. This was therefore offered to S as an option
- Result: successful return to normal eating habits in under a month.

CASE STUDY 2

FISMAN ET AL, 1996
UK

CASE

13-year old girl with high functioning autism

- Autism diagnosed at the age of 4
- Attends regular school program; reading skills are above average; little ability to think abstractly; has no friends and is not involved in any extracurricular activities; had obsessional interests in the past, including people with red hair, convertible cars, the Ninja turtles etc.; obsessive-compulsive washing rituals, checking/closing doors, and constant straightening of furniture;
- Change in eating pattern at the age of 12: a sales clerk in a shopping mall commented on her appearance and advised her to lose weight. Immediately she began to diet.
- Obsessed with her weight and her body appearance
- Weight decreased from 62.3 to 44.1 kg; attempted to purge by vomiting/laxatives; contemplated surgery to ‘correct’ her less desirable body parts

INTERVENTION

Structured behavioural approach, based on the patient's ideal weight range

- Rewarded with on-ward and off-ward privileges as her weight increased
- Patient positively receptive to the imposed firm limits and clear structure
- Refusal by staff and family to be engaged in her obsessive conversation also seemed to reduce her power struggles and agitation
- At 12 months postdischarge, the patient maintained her ideal weight, shifting interest to body building, and no further hospital admissions were needed.

CASE STUDY 3

TATENO ET AL, 2008
JAPAN

CASE

17-year-old female with a diagnosis of pervasive developmental disorder not otherwise specified (PDD-NOS) and AN restrictive subtype

- Exhibited difficulty with social interaction and tended to enjoy solitary activities
- No delay in motor or language development
- Excelled academically
- Behavioral rigidity and a tendency to impose routines
- Hypersensitivity to noises
- Age of 16: Excessive fear of weight gain or obesity; weight dropped from 54 to 29 kg (151 cm)
- Sleep disturbances

INTERVENTION

Pharmacological treatment

- Olanzapine, starting at 2.5 mg and increasing to 5 mg after 2 weeks
- Weight gain in 6 weeks; abnormal eating habits remitted in 4 months

CASE STUDY 4

SARI S.A, 2018
TURKEY

CASE

A 14-year-old autistic male

- Diagnosed with ASD in childhood; speaking skills inadequate
- ED symptoms started after his sister had left home for college education: binge-eating episodes followed by self-induced vomiting; lost 18kg (>15% of his body weight) in 1.5 months
- Rejected solid food and completely stopped eating solid food for 10 days
- Thought content regarding body image could not be evaluated, therefore diagnosed with feeding or eating disorder not elsewhere classified (FED-NEC)

INTERVENTION

- **Pharmacological** treatment: 15mg/day olanzapine to prevent vomiting episodes and increase appetite
- **Behavioural** management: rewarded with his favourite foods when he finished his meal and did not try to vomit
- **Stressor** management: In hospital, the patient was accompanied by his sister and fed only by her
- Nutritional habits recovered and discharged 1 month after admission

RECAP

SIMILARITY 1

Early diagnosis:
Autism was diagnosed before the patients developed ED symptoms

SIMILARITY 2

Young patients: 14 yrs

SIMILARITY 3

Predominantly **behavioural** approach; patients positively receptive to clear structures and boundaries.
Stems from intensive behavioural treatment for young people with autism.

SIMILARITY 4

Preoccupation with weight, typically associated with AN, is present in these autistic cases too, but can reflect more of an **obsession** trait and/or a response to an environmental **stressor**, and **less to do with the thin ideal**

ADDITIONAL CHALLENGES

IN CLINICAL SETTING

LATE DIAGNOSIS

Patients do NOT come with a confirmed diagnosis of autism; Some patients only have their diagnosis confirmed AFTER admission to the service

ADULT PATIENTS

Autonomy and independence
Social needs and work functioning
Exacerbation of early life difficulties

COMORBIDITIES

Depression
Anxiety
Personality disorders
Obsessive-compulsive disorder
ADHD
...

PEACE APPROACH

ASD ASSESSMENT

The following **ASD assessment tools** are incorporated:

- Autism-spectrum Quotient (AQ-10)
- Autism Diagnostic Observation Schedule (ADOS)
- Social Responsiveness Scale
- Autism Diagnostic Interview-Revised (ADI-R)

STRUCTURE & DELIVERY

Ensure **consistency**: time and location of sessions are kept regular;

Language use: concise, straightforward, and clear; frequent repetition if needed; clear examples; reduce metaphors

Person-centered approach

RESOURCES FOR ASD

Communication passport
Colourful visuals
Sensory wellbeing workshop
Environmental adaptations
Self-soothing strategies
Handouts, worksheets and summaries

WE ARE STILL LEARNING

From each individual case, and from new research evidence on autism and eating disorders.

THANK YOU!

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