Eating Disorders in children and adolescents

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Disclosure

- The presenter has no financial relationship to this program.

Objectives

At the end of this presentation, participants will be able to:

1. Reference current diagnostic schema in accessing patients with eating disorders.
2. Evaluate medical and psychosocial needs for patients with eating disorders, of multiple ages and medical status.
3. Appropriately refer patients to eating disorder programs.

Introduction

- Goal: Provide an overview of eating disorders
  - Diagnosis
  - Suggestive signs/symptoms
  - Etiology
  - Intervention
  - Medical and safety monitoring
  - referral

Gratitude

- Thank you:
  - Participants!
  - ECHO
  - UNM Department of Psychiatry
  - Eating Disorder Treatment Center of Albuquerque
  - ACUTE treatment center (Denver Health hospital)

- Disclosures: none

Background

- Reflection
  - Experiences working with patients/clients with eating disorders
  - Challenges
  - Assessment tools/techniques
  - Referral and education sources
- What would you like to learn/improve?

Eating Disorders

- What comes to mind with this term?
    - Reactions
    - Stigma
    - Barriers to care?
- Challenges
    - Not enough time
    - Not routinely asked about
    - Uncertain how to approach
    - Patient resistance/denial
    - Comorbid diagnoses

Factoids – why should we care?

- about 24 million Americans have disordered eating; maybe 8-10 million with formal ED
  - ED: 3rd most common chronic illness in adolescents
  - ED: **highest mortality rate** of any mental illness
- 10-20% of people with AN will prematurely die of complications related to disorder
- Mortality from AN: 12x higher than all cause for females 15-24

Factoids

- Athletes
- LGBTQ
- Adolescence and mid-life
- Males (perhaps less thought of)
- Those under stress ☺ another means of manifesting anxiety
  - So most of our population?

Case Example

- 15 yo Caucasian female presents to clinic for a follow-up
- noticeably thinner than last visit 2 months ago
- Hx of anxiety, depression; previously “normal” – slightly overweight
- Excited to have joined the dance team, and is doing well in school
- Reports depression is better, but mom says she has been less engaged with the family
- Mom just today recognizes weight loss as per intake assessment

Case Example

- How would you question the patient and her mom on the weight loss?
- Do you have routine questions?
- What might be “red flags” for an eating disorder?

Screening

- Suggested questions (routine?)
  - How do you feel about your eating?
  - Do you intentionally restrict intake? (calories/food groups?)
  - Do you overeat? (stress, boredom, coping)
  - Purging behaviors (vomiting, laxatives, exercise)
  - How is your relationship with your body?
    - Feelings about body image, self-esteem, size

Screening/Evaluation

- Scales
  - Yale-Brown-Cornell eating disorder scale
  - Eating Attitudes Test (EAT)
  - Eating Disorders Inventory

Red Flags

- Changes in weight, associated somatic and medical concerns
- Family reports of changes in eating, exercise, other associated behaviors
- Avoidance of meals, cooking for others but not eating
- Disappearance of food

DSM - V

Diagnostic Criteria: Feeding and Eating Disorder

Feeding and Eating Disorders: DSM V

- Persistent disturbance of eating or eating-related behavior that results in altered consumption or absorption of food
- And significant impairs physical health or psychosocial functioning
- Can include extreme emotions, attitudes, and behaviors surrounding weight and food issues

DSMV: Subtypes

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Other/Unspecified eating or feeding disorder
- Pica
- Rumination Disorder

Pica

- A. Persistent eating of nonnutritive, nonfood substances over a period of at least one month
- B. Eating of nonnutritive, nonfood substance is inappropriate to the developmental level
- C. Eating behavior is not part of a culturally supported or socially normative practice
- if it occurs in context of another mental/medical disorder, it is severe enough to warrant clinical attention

Rumination Disorder

- repeated regurgitation of food over a period of at least 1 month (re-chewed, re-swallowed, spit out)
- not attributable to an associated GI or other medical condition
- not occurring in course of another eating disorder
- if in another mental/medical disorder, severe enough to warrant evaluation

Avoidant/Restrictive

- Disturbance in eating or feeding, as evidenced by one or more of:
  - Substantial weight loss (or absence of gain)
  - Nutritional deficiency
  - Dependence on a feeding tube or supplements
  - Significant psychosocial interference
- Not due to unavailability of food, no other ED/MH/medical disorder

Avoidant/Restrictive

- Note **lack of focus** on body image, weight
- No compensatory behaviors to achieve weight goals
- Less common, more so in younger children

Anorexia Nervosa

- Restriction of energy intake relative to requirements leading to a significantly low body weight (not BMI!) in the context of age, sex, developmental trajectory, and physical health

- intense fear of gaining weight or becoming fat, interfering with weight gain, even though underweight

- disturbance in the way in which one's body weight or shape on self evaluation, or denial on the seriousness of the current low body weight

Anorexia Nevosa (cont)

- **restricting** type (not engaged in binge eating or purging) - weight loss through diet/fast/exercise

- **binge eating/purging -** individual has engaged in recurrent episodes of both

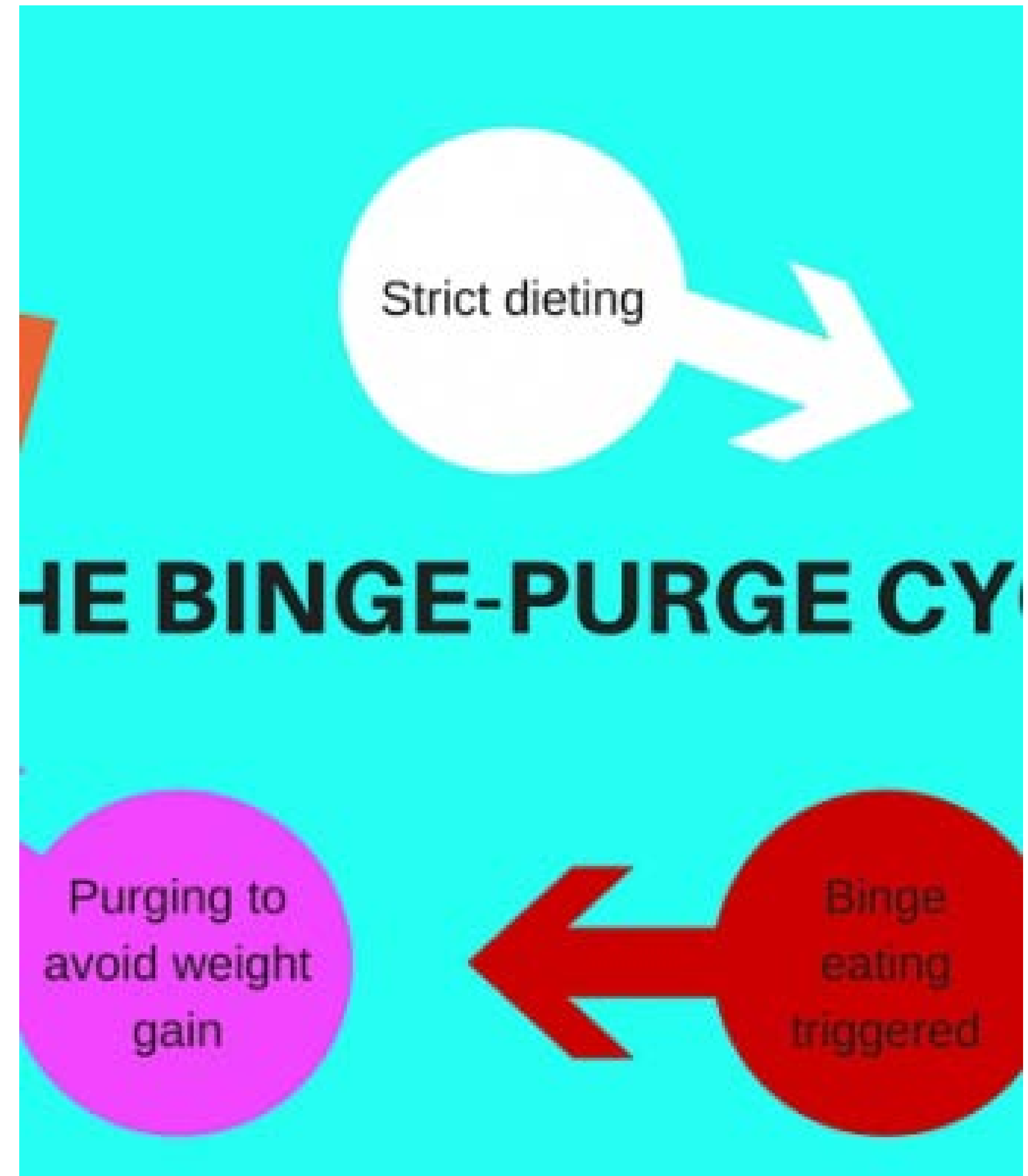
  - Severity:
    mild: BMI > 17; moderate >16, severe > 15, extreme < 15

Bulimia

- Recurrent episodes of binge eating characterized by BOTH;
  - eating in a discrete amount of time (within 2 hour period) **large amounts** of food - larger than what most would eat in that situation
  - sense of **lack of control** over eating during an episode
- Recurrent inappropriate **compensatory** behavior to prevent weight gain

Bulimia

- binge and compensatory behaviors both occur, on average, at least **once a week**
- Self evaluation is unduly influence by body shape and weight
- disturbance does not occur exclusively during periods of anorexia



Binge Eating Disorder

- Recurrent episodes of binge eating, characterized by both:
  - eating, in a discrete period of time, an amount of food large than most people would eat/similar time and circumstances
  - A <u>lack of control</u> over eating during the episode

BED

- Binge eating associated with 3 or more:
  - eating more rapidly than normal
  - until uncomfortably full
  - large amounts of food when not hungry
  - alone because of embarrassment
  - feeling disgusted in oneself

BED

- marked distress regarding binge eating is present
- binge eating occurs, on average, about once a week
- not associated with recurrent use of inappropriate compensatory behaviors (laxatives, purging)

FED NEC

- Feeding and Eating Disorders not elsewhere classified
  - Atypical Anorexia
  - Bulimia of low frequency
  - BED of low frequency
  - Purging disorder: recurrent purging to influence weight or shape without binging
  - Night Eating Syndrome: recurrent episodes of night eating — causes distress

Clinical observations

- Anorexia: more often seen with OCPD/anxiety – harder to treat (especially the longer present)
- Bulimia – often with axis II/trauma hx
- Often co-occurring with other diagnoses
- High comorbidity with substance use disorders

Contributing Factors

- Biology: genetics, environment.
  - Women with mother or sister with AN about 12 x more likely to develop, 4x more likely to develop BN
- Social factors: media, airbrushing, societal factors
- Psych comorbidity: anxiety, PTSD, depression
- Trauma or bullying hx

Case Example

- Back to your interview …
- patient denies restricting or purging
- Acknowledges caring about her body image because of the dance team
- Mom reports she eats by herself a lot, has been "really busy"
- What else would you suggest at this point in time?

Case Example – Early Intervention

- Curiosity/planting seeds
  - "Sometimes when under pressure or stress, people change their eating to gain better control"
  - Discuss closer monitoring with mom
  - Frequent follow-ups
  - Asking and attention may be most important
  - Other ideas?

Case Example

- 3 weeks later, mom calls concerned that her daughter "almost passed out" (dizzy, weak) on the way to school that morning and school nurse asks her to be evaluated

- Steps in medical evaluation … and further psychological evaluation

Medical care of patients with ED

- End Organs affected
  - Brain (nutritional depression, “brain fog”)
  - Endocrine (thyroid, body temperature, adrenal)
  - Cardiovascular (arrythmias, heart failure/strain, changes in blood pressure)
  - Gastrointestinal (gastroparesis, delayed emptying, gastric rupture/dilation, esophageal issues, SMA syndrome)
  - Dermatologic (changes in skin quality)
  - Bone (osteoporosis, poor dentition)
  - Electrolyte abnormalities

Medical Care

- Basics to Medical Care
  - Vitals
  - Height/weight (current and rate of change)
  - Urinalysis (osmolality,) UDM
  - Laboratories
    - Chem 7, CBC, LFT (weight loss)
    - Lipids, Chemistry, HgA1c (weight gain)
  - EKG
  - Bone scan
  - Dental care

How to decide on levels of care?

- Medical stability (vitals, organ dysfunction, electrolyte disturbance)
- Suicidality
- Weight (< 85% often challenging in less structure)
- Motivation
- Ability to improve at other structured care
- Co-occurring behaviors

Suggested criteria - hospitalization

- HR < 40
- QTc > 500
- Rhythm other than sinus
- < 70% IBW
- K < 2.8

- HCO3 > 37
- Excessive edema with cessation of purging
- Hypoglycemia
- Rapid weight loss
- Risk of refeeding

- Weight is NOT sole criteria for

Electrolyte

- Purging
  - Potassium – decreased levels: arrhythmias, (death?)
  - Sodium – elevated
  - Bicarbonate – elevated
- Re-feeding
  - Shifts in Phosphorus with rapid re-feeding
  - Can be very dangerous – need to approach slowly and with monitoring
  - Edema (shifts in fluid)

Medical care take-aways

- Involve multi-disciplinary care team
  - Primary medical providers
  - Psychiatrists
- Many Emergency room providers are less familiar with nuances to eating disorder care
  - Having a strong advocate can be helpful
- Balance of mindfulness of medical fragility;
- With reassurance for certain somatic concerns
- Relative medical state impacts level of care …

Evaluation

- Psychiatric/Psychological functioning
- Medical
- Substance
- Family/support
- Other providers

Psychiatric Evaluation

- Eating disorder:
  - History/family history
  - Behaviors (restricting, binging, purging, exercising)
  - Insight and family functioning
  - Current functioning/impairment in daily life (social, emotional, work, school)

Evaluation - Comorbidities

- obsessions/compulsions (AN?)
- trauma hx (& relationship to behaviors)
- self harming behaviors
- coping skills
- Mood and anxiety symptoms
- Safety - suicidality
- substance use

Substance

- Specific substance
- How is it contributing to eating disorder?
- As a coping skill (alcohol, benzos -> anxiety)
- Often need to treat before ED can be adequately addressed (quick fix)

Social

- Support system – often limited
- adolescents/adults: family
  - Understanding of illness
  - Family hx
  - Contribution to eating disorder
- Isolation/avoidance, impairment

Levels of Care

- Outpatient
- Intensive Outpatient
- Day Treatment
- Residential Treatment
- Inpatient

Eating Disorder Care

- Goal: multidisciplinary
  - Medical
  - Psychiatric
  - Therapeutic (supportive care)
  - Nutritional
  - PT/OT, speech

Goals of Treatment

- Nutritional Rehabilitation (weight, eating patterns, perceptions)
- Psychosocial intervention (support, family)
- Medications and somatic treatments
- Relapse prevention

Determining level of care needs

- Considerations:
  - “Big picture” – overall physical condition, psychology, behaviors, social circumstances
  - Physical parameters: weight compared to healthy weight, rate of loss, metabolic status, cardiac function

Nutrition Goals

- Eating programs (refeeding, maintenance)
  - Intuitive
  - exchanges
- Fluid balance
- Balanced weight gain or loss
  - Target weights – 2-3 lb increase/week inpatient; 0.5-1 lb/week outpt
- ? Tube feed needs
  - Voluntary vs involuntary

Challenges with weight gain

- Resurgence of symptoms/anxiety/self harm urges
- Mild fluid retention with early re-feeding, or more prolonged if stopping laxatives
- Pseudo Bartter's, vs edema with anorexia
- Delayed gastric emptying from malnutrition

Challenges with obesity

- Diet and exercise plans
- Surgery/band?
- Mindfulness of supplements, substances

Medication Interventions

- SSRI’s/antidepressants
- Naltrexone (decreased binge/purge)
- Vyvanse (FDA 2015 for BED - dec binge eating days/week and obsessive/compulsive behavior)
- Antipsychotics (Zyprexa, Seroquel)
- Mood stabilizers (Topomax)

Medications

- SSRI’s – no evidence in acute anorexia; perhaps in relapse prevention
- Atypicals – Abilify included – for decreasing obsessive thoughts
- Some low dose anti-anxiolytic or antipsychotic around meals
  - Monitor more carefully for side effects

Therapy

- Important tenant to care
- Types:
  - FBT (Maudsley)
  - Individual, group
  - DBT, CBT
  - Yoga
  - Mindfulness based

FBT/Maudsley Approach

- Intensive outpatient treatment where parents play an active and positive role in order to help
  - Restore child's weight to normal levels
  - Control of eating back to adolescent
  - Explain role of these issues to the child

- Multiple sessions, in phases

FBT/Maudsley Approach

- Weight restoration phase
  - Focused on dangers of malnutrition
  - Assess family’s interactions and eating habits
  - Align parents with children
- Returning control to adolescent phase
- Establishing healthy adolescent role

How to refer

- Albuquerque
  - Eating Disorder Treatment Center of Albuquerque
  - Eating Disorder Institute (Rio Rancho)
- Consider local therapists who are comfortable with/educated about eating disorders
- Regionally
  - University of Colorado
  - Eating Recovery Center (multiple locations)
  - Rosewood, Remuda (Arizona)

Referral

- Insurance
  - Not all accepted; often costly
- Involuntary treatment needs?
- Connecting with families, schools
- UNM (me)

Resources

- Alliance for Eating Disorders Awareness website (allianceforeatingdisorders.com)
- Academy for Eating Disorders (www.aedweb.org)
- Eating Disorders Referral
- Books as per webpage above

Questions

- Thank you for your time!
- I appreciate any and all feedback ☺