EATING DISORDERS IN CHILDREN AND ADOLESCENTS

Kristina Sowar MD
UNM Dept Child and Adolescent Psychiatry
10/20/2015

INTRODUCTIONS

Thank you:
UNM Department of Psychiatry
Eating Disorder Treatment Center of Albuquerque

Disclosures: none

INTRODUCTION
EATING DISORDERS

Definitions/Diagnoses
Signs and Symptoms
Etiology
Treatment
Resources

BACKGROUND

Experiences with Eating Disorders
- clinical
- personal/family

Questions / Topics to Address?

INTRODUCTIONS

What do we think of when we hear “eating disorders?”

Reactions?

Stigma?

EATING DISORDERS

DSMV: "characterized by a persistent disturbance of eating or eating related behavior that results in altered consumption or absorption of food, and that significantly impairs physical health or psychosocial functioning."

Extreme emotions, attitudes, and behaviors surrounding weight and food issues

SUBTYPES - DSMV

Anorexia Nervosa
Bulimia Nervosa
Binge Eating Disorder
Other/Unspecified Feeding or Eating Disorder
Pica
Rumination Disorder

ANOREXIA NERVOSA

Restriction of energy intake relative to requirements -> significantly low body weight

less than minimally expected, or failure to meet growth trajectory

intense fear of gaining weight / becoming fat

disturbance in the way one’s body weight or shape is experienced, undue influence of body weight on self-evaluation

lack of recognition of seriousness of current body weight

ANOREXIA NERVOSA

Restricting Type vs Binge-eating/purging type
Severity specified on BMI

global body image versus *specific*
Prevalence: 0.4% amongst females,
10:1 female: male
CMR: 5% per decade

ANOREXIA WARNING SIGNS

Behaviors:

- preoccupation with food, calories, dieting, cooking
- refusing to eat/restricting certain foods or groups
- comments about feeling fat or anxiety about body
- denial of hunger
- development of food rituals (small pieces, slow, order)
- avoiding mealtimes, situations involving food
- social withdrawal

HEALTH CONSEQUENCES

Affects multiple organ systems:

- CV: Bradycardia, heart failure, low blood pressure
- decreased bone density
- muscle loss/weakness
- dehydration, peripheral edema
- depressive signs (can be physiological)
- dry skin, hair, lanuga

LAB FINDINGS

CBC: leukopenia
Chemistries:
elevated cholesterol/LFT
low phosphate, magnesium
alterations in Cl/K if vomiting
Endocrine
low sex hormones

ETIOLOGY

genetics (ED, mood sx)

obsessive-compulsive tendencies, anxiety

onset

- life stressor
- initial weight loss (diet, virus) -> -> -> spirals

societal/cultural

SAMPLE CASES

14 yo female, started dieting last year - received compliments so continued to lose weight, restrict food, increased exercise. Down to 500 calories/day, BMI 14, admitted for pericardial effusion. Stabilized inpatient and transitioned to outpt.

14 yo female, lost 10 pounds viral illness, continued to lose to BMI 16. Anxiety, BPAD, home schooled - in outpt, improved with medications.

BULIMIA NERVOSA

eating in a discrete period of time, amount of food larger than *most* would eat in that time/circumstance

lack of control over eating during the episodes

recurrent inappropriate compensatory behavior to prevent weight gain

at least once/week for 3 months

self evaluation unduly influence by body shape and weight

BULIMIA NERVOSA

Cycles of binging and compensatory behavior (purging)
binge: eating relatively large amount of food in short period of time (2 hours,) “out of control”
purging: vomiting, laxatives, exercise
Near normal or above body weight
severity based on number of episodes/week

BULIMIA WARNING SIGNS

Disappearance of large amounts of food

Frequent trips to bathroom after meals, evidence of laxative use

excessive exercise routines

swelling of cheeks (parotid glands)

calluses on hands from vomiting

discoloration of teeth

social withdrawal

BULIMIA COMPLICATIONS

Electrolyte disturbance
Inflammation/rupture of the esophagus
Dental issues
Chronic irregular bowel movements
Gastric rupture

ETIOLOGY/PREDISPOSING FACTORS

Temperament (weight concerns, low self-esteem, social anxiety)
hx of abuse (physical or sexual)
childhood obesity and pubertal maturation

BULIMIA FACTOIDS

about 80% female/ 20% male
onset before puberty or after 40, unusual
often accompanies mood dysregulation, trauma/abuse,
borderline personality traits
crossover from bulimia <-> anorexia

SAMPLE CASE

16 yo Hispanic female

- presents to ICU severely hypokalemic
- recently withdrew from school
- reports purging when upset, when feeling full, or worried about weight.
- normal weight

BINGE EATING DISORDER

Recurrent episodes of binge eating that must occur, at least once/week for 3 months
“binge” - eating in a discrete (~2 hours) period of time, that is definitely larger than most people would eat in a similar period of time under similar circumstances
with marked distress

BINGE EATING DISORDER

Recurrent Episodes of Binge Eating

≥3:

- eating more rapidly than normal
- until uncomfortably full
- large amounts when not feeling hungry
- alone because of embarrassment
- feeling disgusted with oneself/guilty

Marked distress re: binge eating

at least once/week for 3 months

BINGE EATING DISORDER

Severity: based on number of episodes/week
occurs with both “normal” and overweight individuals
12 month prevalence: 1.6% females, 0.8% males

BINGE EATING COMPLICATIONS

- metabolic issues
  - elevations in blood sugar, cholesterol, BP
- gastric complications
- obesity and weight related issues
- self esteem and shame complications

UNSPECIFIED EATING DISORDER

not meeting full criteria for another diagnosis, but still cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

HOW TO HELP?

Awareness in assessing / evaluating warning signs
Working within degree of insight and family systems
Coordinating interventions
Creating Supportive Environments
Preventative Care

TREATMENTS

Multidisciplinary:

- Therapy (CBT, DBT, Family)
- Nutrition/Dietician
- Physician / Psychiatrist
- Intensive Outpatient
- Inpatient (Medical vs Residential)

FAMILY WORK

age of patient re: privacy/disclosure of information
family member feelings about illness
attempts to intervene
awareness of “identified patient”
control vs safety

NUTRITIONAL ASSESSMENT

daily intake
restrictions/avoidants
calories and nutritional breakdown
assessing for re-feeding syndrome
expenditure

TREATMENT

Medical Interventions:
- Weight/BMI
- Labs
  - CBC/Chemistries/LFT/Lipids
  - Celiac?
- EKG

TREATMENT

- Medications
  - antidepressants
    - SSRI’s, mirtazapine
    - weight dependent
  - anxiety remedies
  - antipsychotics (Olanzapine)
  - Stimulants (Vyvanse)

LEVEL OF CARE DECISIONS

Outpatient Therapy / Nutrition
Intensive Outpatient Programs
Partial Hospitalization
Residential
Inpatient

DETERMINING LEVEL OF CARE …

safety (suicidal ideation? self harm?)
supervision/monitoring
ability to eat/maintain weight at lower levels of care
other life stressors, activities

RISK FACTORS/ETIOLOGY

Genetics (women with mothers with eating disorders - much higher rates)

altered leptin/ghrelin, cholesterol receptors

Family Factors (control, stress)

Societal Pressures

Media Exposure

TARGET POPULATIONS

Males
LBGTQ
College Students
Mid-Life
Diabetes / Chronic Illness

RESOURCES

Local:
Eating Disorder Treatment Center of Albuquerque
Eating Disorders Institute of New Mexico
UNM / Dept of Psychiatry

REGIONAL RESOURCES

Rosewood Inpatient (Wickenberg)
Remuda (Wickenberg)
University of Colorado - Denver Health
Denver Center for Eating Disorder
Mirasol (Arizona)

COST OF CARE / INSURANCE

many insurance companies do not cover various levels of care

advocacy

SOCIAL/MEDIA EXPOSURE

Airbrushing
Pro-ANA websites
comments/feedback on photos/body preoccupation
Focus on fitness

WEBSITES

National Eating Disorders Website
Something Fishy