EATING DISORDERS IN CHILDREN AND ADOLESCENTS

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INTRODUCTIONS

Thank you:
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Disclosures: none
INTRODUCTION
EATING DISORDERS

Definitions/Diagnoses
Signs and Symptoms
Etiology
Treatment
Resources
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
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