Assessment & Treatment of Pediatric Eating Disorders in the Medical Setting

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Disclosures

No relevant financial relationships with ineligible companies

Objectives

- Discuss DSM-5 diagnostic criteria for eating disorders in children and adolescents
- Describe the medical assessment and monitoring of youth presenting with eating concerns
- Review components of Family-Based Treatment and how they can be incorporated in the medical setting to address eating concerns with both the patient and the family

Disordered eating behaviors are common among teens

- 33.16% trying to lose weight
- 19.28% dieting
- 36.46% exercising to change body shape
- 8.91% fasting/skipping meals
- 4.26% engaging in non-exercise compensatory behaviors (purging, weight loss pills, laxatives, and/or diuretics)

National Longitudinal Study of Adolescent to Adult Health
Harris et al. (2019)

More findings

•Girls start to worry about their weight by age 10, and by 14, 60 to 70% are trying to lose weight. (Andersen, 2022)

•Weight-related teasing is a primary way kids are bullied, and kids in larger bodies are significantly more likely to be bullied than their smaller-bodied classmates. (Puhl et al., 2011)

•Girls who were teased about their weight were 1.5 times more likely to binge eat and 1.5 times more likely to use extreme methods of weight control five years later. (Neumark-Sztainer et al., 2007)

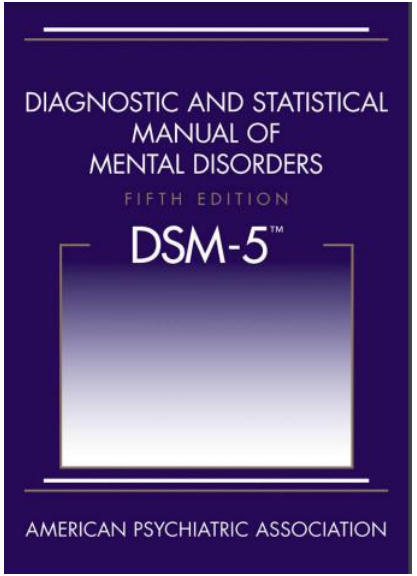
•Just 20% of adolescents with eating disorders seek treatment. (Forrest et al., 2017)

•Hospital admissions and outpatient referrals for adolescent eating disorders increased during the pandemic and have not returned to pre-pandemic levels. (Milliren et al., 2023)

DSM-5 Criteria

DSM-5 (2013)

- FEEDING AND EATING DISORDERS
  - Avoidant/Restrictive Food Intake Disorder (ARFID)
  - Anorexia Nervosa (AN)
  - Bulimia Nervosa (BN)
  - Binge-Eating Disorder
  - Pica
  - Rumination Disorder
  - Other Specified Feeding or Eating Disorder (OSFED)
  - Unspecified Feeding or Eating Disorder



https://repository.poltekkes-kaltim.ac.id/657/1/Diagnostic%20and%20statistical%20manual%20of%20mental%20disorders%20_%20DSM-5%20(%20PDFDrive.com%20).pdf

American Psychiatric Association. (2015). Diagnostic and statistical manual of mental disorders (5th ed.)

Anorexia Nervosa

- Restriction of energy intake relative to requirements, leading to significantly low body weight
  - For children, BMI%ile < 10
  - For adults, BMI < 17.5
- Intense fear of gaining weight or becoming fat, or behavior that interferes with weight gain
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight/shape on self-evaluation, or lack of recognition of seriousness of low body weight
- Subtypes: Restricting, Binge/purge

American Psychiatric Association. (2015). Diagnostic and statistical manual of mental disorders (5th ed.)

ARFID

A. An eating or feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with 1 or more of the following:
   1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children)
   2. Significant nutritional deficiency
   3. Dependence on enteral feeding or oral nutritional supplements
   4. Marked interference with psychosocial functioning

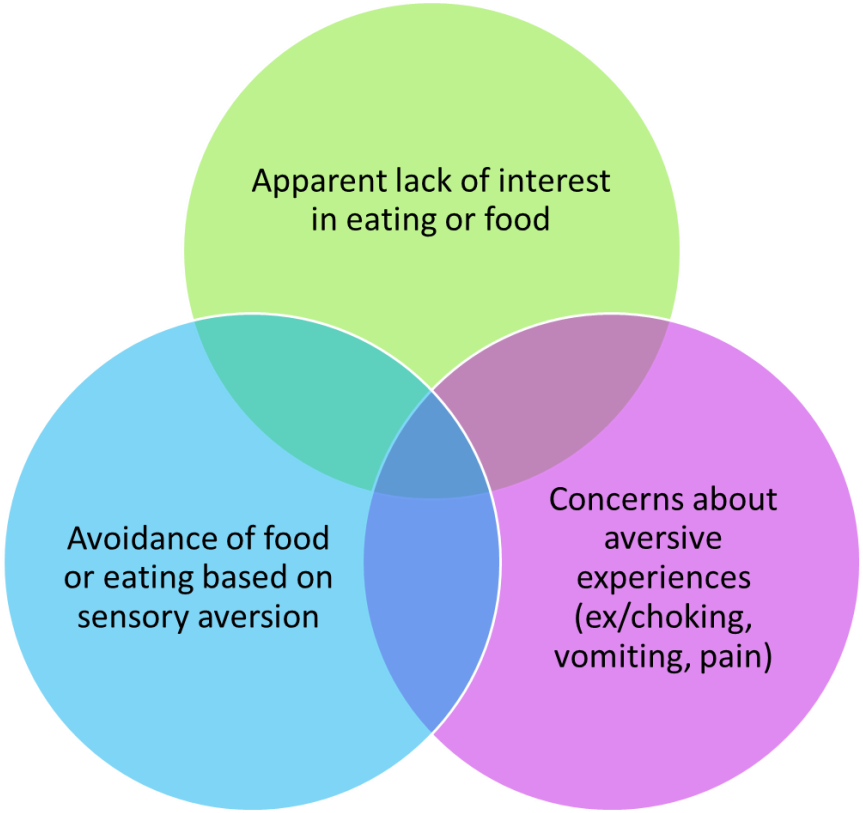
B. Disturbance is not better explained by lack of food or culturally sanctioned practice

C. Does not occur exclusively during the course of AN or BN and no evidence of a disturbance in way in which body weight or shape is experienced

D. Eating disturbance not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

American Psychiatric Association. (2015). Diagnostic and statistical manual of mental disorders (5th ed.)

ARFID



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ARFID or AN?

- 14-year-old female with history of anxiety develops reflux and vomiting
- Starts restricting eating to avoid physical symptoms
- Extensive GI work-up is negative
- Reports exercising to cope with anxiety
- Lost weight and is at 85% median body weight and is currently bradycardic
- PCP recommends hospitalization

- Patient later acknowledges vomiting was intentional
- Patient had been bullied for appearance and started exercising to get “healthy”
- Patient demonstrated fear of fat and body image distortion

Bulimia Nervosa

- Recurrent episodes of binge eating
- Recurrent inappropriate compensatory behaviors (ie. vomiting, misuse of medications, fasting, or excessive exercise) to prevent weight gain.
- Binge eating and compensatory behaviors occur on average at least weekly for three months
- Self-evaluation unduly influenced by body shape and weight
- Does not occur exclusively during episode of Anorexia Nervosa

American Psychiatric Association. (2015). Diagnostic and statistical manual of mental disorders (5th ed.)

Other Specified Feeding or Eating Disorder (OSFED)

- Atypical Anorexia: All symptoms of AN are met but despite significant weight loss, weight is within or above the normal range (BMI%ile>10)
- Bulimia nervosa of low frequency/duration
- Binge-eating disorder of low frequency
- Purging disorder
- Night eating syndrome

American Psychiatric Association. (2015). Diagnostic and statistical manual of mental disorders (5th ed.)

Medical Assessment and Management

Kate

May 2023: 115 lbs (BMI 20.4, 56th %ile)

--Decided to “get in shape”

May 2024: 105 lbs (BMI 18.6, 18th %ile)

--Avoids eating with family

--Periods stopped 3 months ago

https://www.childrens.com/wps/wcm/connect/childrenspublic/d941305c-50a8-47dd-b7a9-94e48245f5c1/shutterstock_498562579_800x480.jpg?MOD=AJPERES&CVID=

Kate

3 months later: 95 lbs (BMI 16.9, 5th%ile)

--Exercise is driven and compulsive

--"I can't eat if I haven't exercised."

3 months later: 88 lbs (BMI 15.6, <3rd %ile)

--75% MBW, HR 44

--Medical hospitalization

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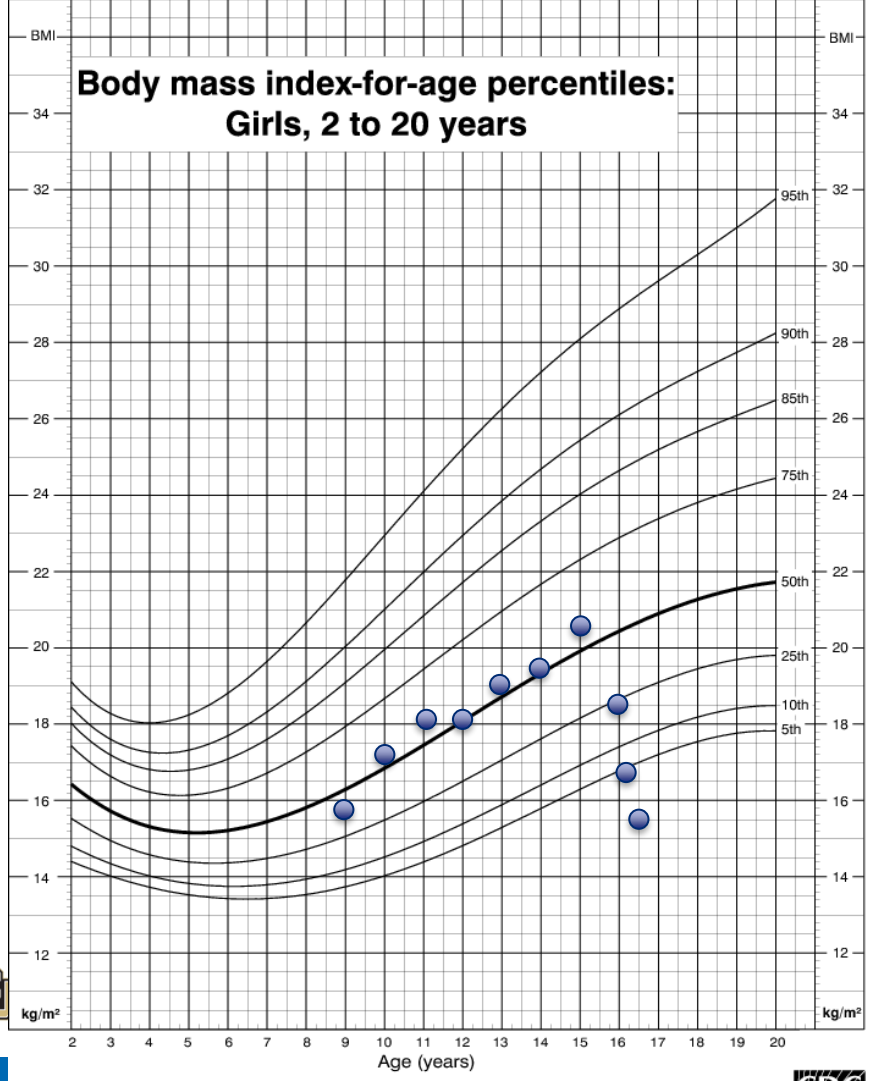

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https://www.cdc.gov/growthcharts/data/set1clinical/cj41l024.pdf

Gathering Patient History

- “What do you think is going on with your body to make you lose weight?”
- Personal story of disordered eating behaviors
- Timing of maximum and minimum weights
- Menstrual history-age/weight at menarche and LMP, frequency of periods
- Body dissatisfaction

Energy economics

- Dietary practices
  - Specific 24 hr dietary recall
  - Fluid intake - water, caffeine
  - Changes in eating habits - variety, taboo foods, fads, rituals
  - Label reading, counting calories, fat grams, tracking with apps
- Exercise
  - Specific activities - frequency, intensity, duration
  - Organized sports/classes
  - Independent activities
  - Secretive activities

Physical exam and labs

- Height - stadiometer
- Gown weight (post void, backward on scale)
    - Office approaches to standardize care and promote positive interactions
- Calculate % Median BMI
    - Current BMI/expected BMI at the 50th %ile for age and gender
- Resting HR
- Orthostatic VS (HR, BP)
- Complete PE including SMR staging
- Labs: CBC with diff, CMP, Ca, Mg, Phos, TSH, UA
- +/- labs: HCG, Vit D, ferritin, Celiac disease serology
- EKG

Indications supporting hospitalization

- ≤75% median BMI for age and sex
- Dehydration
- Electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia)
- EKG abnormalities (e.g. severe bradycardia or prolonged QTc)
- Physiological instability
  - Severe bradycardia (HR <50 day; <45 night)
  - Hypotension (<90/45)
  - Hypothermia (T <96˚F, 35.6˚C)
  - Orthostatic increase in pulse (>20 bpm) or decrease in blood pressure (>20 mmHg systolic or >10 mmHg diastolic)
- Uncontrollable bingeing and purging
- Acute medical complications of malnutrition (e.g. syncope, seizures, cardiac failure, pancreatitis, etc.)
- Comorbid psychiatric or medical condition that prohibits or limits appropriate outpatient treatment (e.g. severe depression, suicidal ideation, obsessive compulsive disorder, type 1 diabetes mellitus)
- Arrested growth and development
- Failure of outpatient treatment

Outpatient medical management

- Goal is to promote steady weight recovery of ½-1 lb/week
- Adjust weight target every 2-3 months for growth
- Increase energy in (implement regular snacks and meals)- parents involved in food preparation and monitoring, may need to involve school
- Reduce energy out (stop extra physical activity)
- Requires weekly visits initially and then decrease frequency, labs PRN clinical status

Managing Exercise

- Gradually increase physical activity with weight restoration
- Patient needs to be in a solid recovery place
    - eating well, consistent weight gain trend
- Suggest minimum of 90% target weight before you allow exercise
- Be specific so that everyone has clear understanding of allowable activity eg. 30 min soccer practice daily
- May need to communicate with coaches
- Always reserve the right to decrease activity if not gaining

Managing Exercise

- Nutritional supplementation
  - 250 kcals/30-45 mins of physical activity
  - Increase in base meal plan kcals
  - When adding back exercise, you might need to increase frequency of visits for monitoring weight
- Avoid bargaining about exercise
  - Parents need limits as much as patients do
- Avoid “Athlete’s Heart” misconception

- Safe Exercise at Every Stage (SEES) Guidelines
  - https://www.safeexerciseateverystage.com/sees-guidelines

Therapy Interventions

Insight

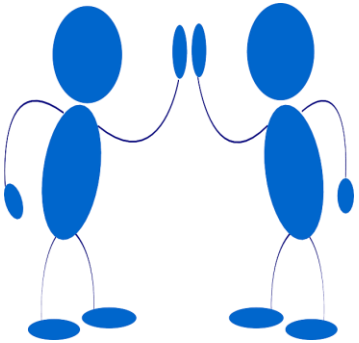
https://stock.adobe.com/search/images?k=insight+icon

https://www.picserver.org/m/motivation.html

Egosyntonic

vs

Egodystonic



https://openclipart.org/detail/81049#google_vignette

https://personalityplaybook.com/2015/10/23/judging-and-perceiving-in-conflict/

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Psychotherapy for Eating Disorders

Individual

- Enhanced Cognitive Behavioral Therapy (CBT-E)
- Acceptance and Commitment Therapy (ACT)
- Dialectical Behavior Therapy (DBT)
- Interpersonal Psychotherapy (IPT)
- Psychodynamic therapies

Family

- Family-Based Treatment (FBT)
  - AKA Maudsley Method
- Emotion-Focused Family Therapy (EFFT)

https://www.weneedtotalk.news/society-body-image/

Key Tenets of FBT

- Parental empowerment
  - Parents are the main agents of change
- Agnostic view as to the cause of the eating disorder
  - Viewed as complex and multifactorial
  - Neither the adolescent nor the parents are to blame for the eating disorder
- Externalizing the illness from the patient
  - The eating disorder is separate from the child and not in their control
  - The child cannot choose to stop their eating disorder behaviors
  - Helps to reduce parental criticism
- Therapist takes a consultative stance
  - Active role in guiding the family to recovery without telling the family exactly what to do
  - Parents are seen as the experts on their family and therapist serves as an expert consultant
- Pragmatic approach
  - Families are to interrupt pattern of restriction and establish weight gain quickly
  - Focus on weight restoration first and then psychiatric comorbidities

Lock & Le Grange, 2015

Emotion-Focused Family Therapy

- Developed as an adjunct to FBT for treatment resistant patients (Robinson et al., 2015)
- Based on the research that eating disorders can be understood as an attempt to control affect (Treasure, 2012)
  - ED patients often experience alexithymia, the inability to identify and label accurately affective experience (Becker-Stoll, & Gerlinghoff, 2004)
  - Starving numbs
  - Binging soothes
  - Vomiting provides relief
- EFFT adds an increased focus on emotion processing skills to enhance the behavioral targets of FBT
- EFFT has parents support their children in processing emotions
  - This increases the child's emotional self-efficacy and strengthens the parent-child relationship
  - Parent becomes "emotion coach"

https://www.youtube.com/watch?v=-4EDhdAHrOg

Steps of Emotion Coaching

1. Attend to the emotion
   "I see that something is up."
2. Name it
   "You look anxious."
3. Validate the emotion
   "I can understand why you might feel anxious. It is scary to try new things, especially when you don't know how it will go."
4. Meet the need
   "I am here and will support you the whole time."
5. Fix it/Problem solve (not always needed)
   "I will help you develop a plan going forward."

https://www.mentalhealthfoundations.ca/

Shortcuts to Validation

Core Skill: Moving from BUT to BECAUSE

I get why you would feel _____ because X 3

I can see how that might make you feel _____ because X 3

It makes sense that you're feeling _____ because X 3

I can only imagine how difficult this must be because… because X 3

No wonder you're _____ because X 3

https://www.mentalhealthfoundations.ca/

Types of Support to Provide after Validating

- Emotional Support
  - Sadness—soothing comfort
  - Anger—feeling heard, creating space, or setting boundaries
  - Shame/anxiety—reassurance
- Practical Support
  - Set limits
  - Redirect
  - Exposure
  - Problem-solve
  - Take over
- If emotions remain at a high intensity, repeat the validation step.
- Validation is needed to open loved one up to the support.

Additional Tips for Caregivers

- Validation does NOT equal agreement.
- Common validation traps
  - Looking on the bright side
  - Trying to educate or rationalize
  - Trying to fix it
- Power of being present with your child in the moment
  - Caregivers need to practice distress tolerance skills too!
  - Joining with their emotions helps them begin to regulate
  - “When you can’t look on the bright side, I will sit with you in the dark.”
- Adolescents with eating disorders often experience alexithymia
  - Parents may need to provide the language for describing emotions

Mealtime Structure

- Parents/caregivers are encouraged to take an active role in preparing meals and supervising meal completion
- Typical daily meal structure:
  - 3 meals (30 minutes)
  - 2-3 snacks (10 minutes)
- Time limits on meals and snacks help set a limit on the eating disorder's attempts to avoid/delay nutrition
- Consistent implementation of time limits and consequences for not completing (e.g., supplemental nutrition or loss of other privileges until meal is complete) takes control away from the eating disorder
- Parents should eat with their child, providing encouragement and redirection

Engaging Schools

- Depending on severity of eating issues, child may need support from school staff to complete lunch and sometimes a morning snack during the school day
  - Parents can be encouraged to request a 504 accommodation plan
  - School staff can report back to parents on meal completion and if child will require supplemental nutrition
- Kids may need to be excused from PE class while weight restoring
- Ability for kid to check in with school counselor or other support if experiencing emotional difficulties during the school day
- Excused absences for medical and therapy appointments

Rewards and Consequences

- Consistent implementation of rewards and consequences can drive behavior change
- Since most kids with eating disorders are not intrinsically motivated to recover, rewards can help increase compliance with treatment.
- Examples:
  - Earning screen time after completing a meal
  - Earning points and eventually a preferred item for trying new foods
- Conversely, we want to convey that nutrition is not optional and failure to complete nutrition will have consequences
- Examples:
  - Loss of cell phone
  - Not being able to see friends
- Consistency is key!!

Common Questions from Parents

- "Why doesn't my teen want to get better?"
  - Eating disorders are ego-syntonic. Many teens do not want to let go of their eating disorder as they are using it to cope with difficult emotions. As their parent, you need to take on the role of fighting this illness for them at the onset.
- "Why can't I let my kid leave the last few bites on the plate?"
  - Even this minor amount of restriction is a "win" for the eating disorder and allows the child to have some control over the eating episode. A few bites quickly becomes whole items and snowballs from there.
- "Can my kid exercise if she is eating meals?"
  - It depends. Sometimes kids are physically ready to resume exercise before they are psychologically ready. If they are still focused on burning calories and using exercise as a compensatory behavior after eating, then it is best to hold off. We recommend starting with family activities like a walk and sports that involve social interaction.

Eating Disorders Program at Children's Colorado

- 7 day a week, partial hospitalization program, family based
  - Extended day 7:30 AM-6 PM (breakfast through dinner)
  - Regular day 8:30-4 (breakfast and dinner at home)

•Team members: Psychiatry, Psychology, Master's level therapists, Registered Dieticians, Nurses, Counselors, Adolescent Medicine consultation

•Therapy: Individual, family, group, multi-family group, parent group, creative arts

•Therapeutic Models: FBT(adapted for higher levels of care), EFFT, Unified Protocol

•Nutrition and Meal structure: 3 meals, 3 snacks. Nutrition is NOT optional.

Children's Hospital Colorado Eating Disorder Program
Intake number: 720-777-6200.

Psychopharmacology
&
Eating Disorders

Psychiatric Co-morbidities (Lifetime)

	AN	BN
MDD	8.7%	31.0%
Bipolar	2.1 %	18.5%
Anxiety	23.9 %	66.2%
Substance Use	13.0 %	20.1%
ADHD	2.3 %	20.0%
ODD	30.4 %	24.4%

Swanson et al., 2011

Medications with FDA approval for Eating Disorders

	Pediatric	Adult
Anorexia Nervosa (AN)	none	none
Avoidant Restrictive Food Intake Disorder (ARFID)	none	none
Bulimia Nervosa (BN)	none	Fluoxetine, target dose 60 mg daily
Binge Eating Disorder (BED)	none	Lisdexamfetamine (for mod to severe BED), target dose 50-70 mg daily
PICA	none	none
Rumination Disorder	none	none

https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/018936s108lbl.pdf
https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/208510lbl.pdf

American Academy of Child and Adolescent Psychiatry (AACAP) Eating Disorder Practice Parameters (2015):

“The use of medications, including complementary and alternative medications, should be reserved for comorbid conditions and refractory cases”

American Academy of Child and Adolescent Psychiatry (AACAP) Eating Disorder Practice Parameters (2015):

Anti-depressants: “useful for comorbid disorders; may be a second-line treatment for adolescents with BN”

Atypical anti-psychotics: “useful for comorbid conditions; further study needed to determine efficacy for core symptoms of AN”

Top Take Aways to Use in Your Practice

- No one thing causes an eating disorder.
- A youth may disclose trouble with eating and ask for help. However, providers and parents should not wait for a youth to request help if they are concerned.
- Early intervention is important.
- Nutrition IS NOT NEGOTIABLE.
- Family-based treatment is recommended and evidenced based for youth.
- No medication FDA approved for the treatment of eating disorders in youth.
- Eating disorders have highest morbidity and mortality among mental health disorders.
- Consultation with colleagues can be helpful.

Websites Resources

NEDA – National Eating Disorders Association

www.nationaleatingdisorders.org

Families Empowered And Supporting Treatment of Eating Disorders (FEAST)

www.feast-ed.org

Academy of Eating Disorders

www.aedweb.org

NIH - National Institutes of Health

www.nlm.nih.gov Search “Eating Disorders”

Information on Maudsley Method

www.eatingwithyouranorexic.com, http://www.maudsleyparents.org/, www.aroundthedinnertable.org

EFFT – Emotion Focused Family Therapy

https://www.mentalhealthfoundations.ca/efft

Safe Exercise at Every Stage (SEES)

https://www.safeexerciseateverystage.com/sees-guidelines

Books for Families

- *Survive FBT: Skills Manual for Parents Undertaking Family Based Treatment (FBT) for Child and Adolescent Anorexia Nervosa* by Maria Ganci
- *Help your Teenager Beat An Eating Disorder* by Jim Lock and Daniel LeGrange
- *Skills-based caring for a Loved One with an Eating Disorder. The New Maudsley Method* by Janet Treasure
- *What Causes Eating Disorders and What do they Cause: An essential introduction for anyone who would like to understand eating disorders and how to overcome them* by Guido Frank

Questions?

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- Image: https://www.weneedtotalk.news/society-body-image/
- YouTube video: https://www.youtube.com/watch?v=-4EDhdAHrOg

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