Eating Disorders in Adolescents: When to Worry & What to Do

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Disclosures

I have no conflicts of interest.
I admit to being an Adolescent Medicine enthusiast. If you find interacting with teenagers challenging, thank you for participating today.
Learning Objectives

• Perform a basic initial assessment for a suspected eating disorder
• Describe criteria for urgent medical stabilization, and the spectrum of higher level treatment options
• Implement strategies for prevention, early intervention, and longer term family support
• Describe the role of the parent/family in management of adolescent eating disorders
Today’s Road Map

- Cases 1 & 2
  - Diagnosis
- Cases 3 & 4
  - Admission Criteria
  - Concepts in ED Management
  - Referral & Levels of Care
- Cases 5 & 6
  - Recovery Goals
  - Supporting Families
Case 1: Is it an eating disorder?
DSM-V Criteria for Anorexia Nervosa

• Restriction of energy intake relative to requirements leading to **significantly low body weight** for age/sex/developmental trajectory or physical health
• Intense fear of gaining weight/becoming fat, or **persistent behavior that interferes with weight gain** despite significantly low weight
• Disturbance of how body weight/shape is experienced, **undue influence on self-evaluation**, **persistent lack of recognition of low body weight**

**SUBTYPES** – restricting, binge-eating/purging
Epidemiology & Classification

• Epidemiology*
  – DSM-IV: Lifetime prevalence of 0.5-2% (AN); 0.9-3% (BN); 4.8% (EDNOS)
  – Peak onset 13-18yo (AN), 16-17yo (BN)
  – Mortality rate 5-6% (AN)

• “New” diagnostic entities
  – Atypical Anorexia
  – Avoidant/Restrictive Food Intake Disorder (ARFID)
  – Binge-Eating Disorder
  – Other Specified Feeding/eating Disorder (OSFED)

When to worry?

Consider ED in patients with:

• Preoccupation with food, body image, restricting and compensatory behaviors

As well as….

• Growth failure
• Pubertal delay
• Overweight/Obesity
• Chronic illness
Case 2: When is weight loss a problem?
Initial Evaluation

• Rule out other medical conditions/comorbidities*
  – Endocrine, GI, Psychiatric or other chronic conditions
• Establish medical stability
  – Gowned weight, PE, Lab evaluation
• Collect an eating behaviors history
  – Don’t forget exercise and menstrual history
• Comprehensive psychosocial ROS
  – HEADSS/SSHADESS

* Don’t forget to screen for food insecurity
Sample History Details

• Food-related behaviors
  – Restricting types or amounts, calorie counting or goals, social eating, response to others’ efforts to get them to eat more

• Symptoms related to eating
  – Physical sensations, anxiety, guilt

• Compensatory behaviors
  – Purging by emesis, exercise, medications/laxatives

• Body image concerns/goals
  – Concern/preoccupation about weight/shape/size
  – Goal weight, knowledge of weight history, weight maltreatment

• Nutritional history – 24 hour recall
Assessing Medical Stability

• ROS
  – Dizziness, syncope, weakness, fatigue, exercise intolerance
  – Edema, palpitations, chest pain
  – Frequency of purging behaviors
  – Approximate daily intake
  – Self injury/suicidality

• Physical Exam findings
  – Bradycardia, orthostatic hypotension or tachycardia
  – Acrocyanosis
  – Edema
Assessing Medical Stability

- Initial evaluation:
  - Complete metabolic panel, Mg, P, UA, TSH
  - Other labs as indicated clinically
  - EKG for bradycardia, symptoms, abnormal electrolytes
Formulating a Plan

• Is it an eating disorder?
• Do I need to admit?
• Do I need to elevate care?
• What other supports does this family need?
  – School support, FMLA, public assistance, care coordination
• Initial close follow up is prudent:
  – Simple interim nutrition plan
  – Track weight trajectory
  – Assess coping and resilience
Levels of Care
(Families need a roadmap too)

• Primary Care
  – Engage nutrition, family or individual therapy, FBT therapist

• Outpatient Specialty Care
  – Medical, Mental Health, Nutrition

• Higher Level Outpatient Care (HLOC)
  – Intensive Outpatient or Partial Hospitalization Programs

• Inpatient/Residential

• Inpatient Medical Stabilization=Urgent nutrition rehabilitation
Case 3: When to admit?
### Criteria for Medical Stabilization

- **Bradycardia:** HR < 50 awake, < 45 asleep
- **Hypotension:** SBP < 90 mmHg
- **Hypothermia:** T < 96°F (< 35.6°C)
- **Orthostatic tachycardia:** (> 20 bpm) or hypotension (> 10 mmHg), or overt syncope
- **Prolonged QTc or other arrhythmia**
- **< 75% IBW, Body fat < 10%**
- **Acute food refusal**
- **Failure to respond to outpatient treatment or weight loss despite intensive management**
- **Intractable vomiting, hematemesis**

Case 4: “Nutrition before Insight”
Key Concepts in ED Management

• Nutrition First
  – Nutritional recovery is a precondition for psychological recovery

• Family Based Treatment (FBT) is the current standard
  – Empowers caregivers to guide weight restoration
  – Employs an “agnostic” approach to remove blame, externalize the disorder
Family Based Treatment: The Maudsley Approach

- Regards parents as the solution, not the problem
- Behavior-focused approach guiding parents to assume an active and primary role in changing maladaptive eating behaviors, and restoring nutritional status at home
- Conducted by a Family Based Treatment (FBT) therapist, over 15-20 sessions (~12 months)
- Not the same as family therapy

*Can you do FBT without an FBT therapist?*
Developmental Continuum of Eating Independence

Eats meal plated by parents

- Parent packs school lunch
- Eats with supervision at school

Makes own plate from multiple choices

- Unsupervised lunch with peers at school

Prepares simple meals

- Packs own lunch
- Outings with friends include snacks/meals

Plans meals, shops/cooks

Case 5: What does recovery look like?
Recovery Goals

**Physiologic**
- Reversal of target organ damage
- Weight/growth restoration
- Restoration of menses/pubertal development
- Safe return to exercise

**Nutritional**
- Maintenance weight achieved through balance and variety
- Flexibility and independence in eating
Recovery Goals

Psychological
• Decreased influence of body image on self esteem/self concept
• Age appropriate functioning
• Improved social function
Case 6: What does recovery look like?
Outcomes

N=121, RCT of FBT vs. AFT, 12-18yo with AN (DSM-IV)  
Lock & LaGrange (201). Atch Gen Psychiatry, 67(10):1025-1032
Tips for Supporting Families

• “It’s a marathon not a sprint”
• Caregivers should present a unified front
• Coach parents to model distress tolerance
• Acknowledge parents’ distress
• Coach parents to be kind AND firm – appearing confident helps too
• Be aware of treatment fatigue
  – Support parents’ self care
  – Support family logistics to optimize engagement in care
Tips for Supporting Families

Families of Young Adults

• Set clear boundaries for parent involvement for youth who can legally make their own health care decisions

• Support emerging decision makers through informed collaboration

• Plan for supported independence

• Set expectations for independence and ensure follow up/resources at college
Wrapping it Up

• Primary care providers have a critical role in the identification and management of adolescent eating disorders
• Early case identification & urgent intervention are crucial
• The new standard is more nutrition, less medication, and family-centered, family-driven care
• Admission may be required to address medical stability
• A spectrum of higher level care provides support at the appropriate level
Wrapping it Up: So what can I do?

• Be vigilant & proactive
  – Identify risk early and intervene quickly
  – A simple nutrition plan may be enough
  – Be thoughtful about sports clearance
  – Refer medically unstable patients for admission

• Know your village
  – What are your options for nutrition and behavioral health support?
  – Where can you refer locally for higher level care?
Wrapping it Up: So what can I do?

• Refer and collaborate
  – Connect families with the right level of care
  – We are happy to help you determine what level is appropriate!
• Support families
  – Stay involved, validate necessary treatment, provide family-centered support
• Think Prevention
  – discourage fad dieting
  – promote health and family meals
  – address weight maltreatment
Recommended Reading (ED 101)


Resources for Families: FBT

www.maudsleyparents.org
Resources for Families: FBT

Help Your Teenager Beat an Eating Disorder

Skills-based Caring for a Loved One with an Eating Disorder
Resources for Families

www.FEAST-ED.org
Resources for Families

1. When Your Teen Has an Eating Disorder
   - Practical Strategies to Help Your Teen Recover from Anorexia, Bulimia & Binge Eating

2. Anorexia and other eating disorders
   - How to help your child eat well and be well
Donald Delaney Eating Disorders Clinic at Children’s National

- **Clinic Director:**
  - Darlene Atkins, Ph.D., datkins@cnmc.org

- **Clinic Location:**
  - CNHS @ Friendship Heights, 5028 Wisconsin Ave

- **Multidisciplinary services:**
  - Medical, Nutrition, Psychology, Psychiatry

- **Coordinated services with CNMC**
  - Psychiatry, FBT, Inpatient Medical Stabilization
Donald Delaney Eating Disorders Clinic
at Children’s National

• **Making a referral**
  – Email or fax referral information to:
    Petrinia Young, Senior Administrator
    peyoung@childrensnational.org
    Fax: 202-237-0694

• **Phone consultation (Adolescent Medicine)**
  – CNHS Physician Access Line, 202-476-4880

• **Emergency Referral for Medical Stabilization**
  – CNHS Main Hospital ED, 202-476-LIFE (5433)
  – Hospital operator for Adolescent Med On Call
    202-576-5000
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