CHILD AND ADOLESCENT EATING DISORDERS: AN OVERVIEW

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Objectives
1. Recognize eating disorder behaviors; identify early warning signs; make an accurate diagnosis.
2. Understand etiology of disordered eating and feeding problems in children.
3. Treatment approaches
4. Prevention strategies

Survey Data
- 42% of 1st-3rd grade girls want to be thinner
- 47% of girls in 5th-12th grade reported wanting to lose weight because of magazine pictures
- Only 5% of females naturally possess the ideal body type presented in the media
- Over 50% of teenage girls and nearly 30% of boys skip meals, fast, smoke, vomit and take laxatives to control weight
- Male athletes in wrestling and cross country are more likely to struggle with disordered eating

National Association of Anorexia Nervosa and Associated Disorders

LGBTQ Youth
- Lesbian, gay or bisexual teens may be at higher risk of binge/purge behaviors than heterosexual peers.
- Among males who have eating disorders, 42% identify as gay.
- Unique set of challenges and stressors contribute to vulnerability

LGBTQ Stressors
- Fear of /or experience of rejection by friends and family
- Internalized negative messages due to sexual orientation, non-normative gender expressions, or transgender identity
- Discrimination due to sexual orientation and/or gender identity
- Being a victim of bullying due to orientation and/or gender identity
- Discordance between one's biological sex and gender identity

National Association for Anorexia Nervosa and Associated Disorders ANAD
New Face of Eating Disorders

- Younger
- Older
- More culturally diverse
- Immigrant youth are experiencing weight loss which is a relatively new phenomenon

Disorder Prevalence vs. Funding

<table>
<thead>
<tr>
<th>Illness</th>
<th>Prevalence</th>
<th>NIH Research Funds (2011)</th>
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</thead>
<tbody>
<tr>
<td>Alzheimer's Disease</td>
<td>5.1 Million</td>
<td>$450 Million</td>
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<tr>
<td>Autism</td>
<td>3.6 Million</td>
<td>$160 Million</td>
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<tr>
<td>Schizophrenia</td>
<td>3.4 Million</td>
<td>$276 Million</td>
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<tr>
<td>Eating Disorders</td>
<td>30 Million</td>
<td>$28 Million</td>
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</tbody>
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Early Warning Signs of Eating Disorder

- Unexplained weight loss in child or teen
- Reduced intake described as "Eating Healthy"
- Refusal to carbs, fats or proteins
- Avoiding mealtimes or eating in front of others
- Preparing food for the family, but refusing to eat the meal
- Vegetarianism
- Weight loss in the high BMI patient
- Weight loss in the athlete explained as "conditioning"

The Common Narrative

- Wanted to improve conditioning, toning
- Wanted to eat healthier; reduced junk food, sweets
- Increased exercise; counted calories; decreased or eliminated fats
- Felt guilty if deviated from these practices
- Received compliments
- Thought I was in control…but now I’m not

Diagnostic Criteria
Eating Disorder Diagnosis DSM-IV
Criteria and Symptoms

Anorexia Nervosa (AN)
- Low weight; BMI 18 or below
- Restriction of nutritional intake
- Intense fear of weight gain or becoming fat even though underweight
- Distorted view of body weight, size or shape
- Undue influence of weight on self-evaluation
- Type I: Restricting; no binge/purge behaviors in last 3 months. Weight loss achieved through dieting, fasting, exercise
- Type II: Binge Eating/Purging behaviors

Bulimia Nervosa (BN)
- Normal weight
- Recurrent binge eating at least 1x/week; 3 months
- Lack of control over volume and rate of consumption
- Recurrent vomiting, laxative abuse, diuretics, fasting, excessive exercise
- Excessive concern regarding body size/shape
- 2.4-4.8% incidence rate

Other Specified Feeding or Eating Disorder
- The most common ED diagnosis in clinical and community
- It includes partial syndromes of AN and BN and Binge Eating Disorder (BED)
- Atypical anorexia nervosa: All of the criteria for AN are met, except despite weight loss, weight is in within the normal range (high BMI individuals)
- Bulimia nervosa: All criteria are met except that the binge eating and inappropriate purging behaviors occur, on average, less than once a week.
- Night eating syndrome: Recurrent episodes of night eating, after awakening from sleep or by excessive food consumption after the evening meal.

Female Athlete Triad
Three Components
- Disordered eating or insufficient energy intake
- Low bone mass
- Amenorrhea
- Continuum of severity from health to disease
- Healthy equals optimal energy, normal menstruation and optimal bone health
- At the unhealthy end, energy deficiency, abnormal menstrual cycles, bone loss

Disordered Eating vs. Eating Disorder
- Chronic dieters, excessive exercise, binge/purge behavior
- Many of the same medical problems as AN and BN
- Depression, low self-esteem when weight loss fails
- Obsessive thoughts about food and eating
- Unlikely to seek treatment or be referred for assessment
- Low parental intervention if chronic dieters themselves

Eating Disorder Assessments
- Eating Attitudes Test (EAT-26) is the most commonly used self-report measure
- Eating Disorder Diagnostic Scale (22 items) developed with good content validity
- Clinical Interview with DSM-IV
- Patient and parent self-report clinical interview
FACTORS THAT TRIGGER EATING DISORDER BEHAVIORS

Risk Factors for Eating Disorder
- Adolescence
- Genetic predisposition for family history of AN
- Early puberty or being tall is linked to poor body image
- Drive for thinness
- Body dissatisfaction
- Early dieting urged by parent
- Paternal criticism of weight correlated with ED behaviors
- Childhood anxiety, OCD
- Parental disordered eating

Negative Impact of Media Images
- Definition of beauty is narrow and impacts the way teens feel about themselves
- Definition has little or no respect for the biological and genetic realities of young girls and women
- Ignores cultural and racial differences
- Convinces girls they can and should have the bodies of athletes (highly defined musculature)

Changes in Beauty Standard
- Images of women have become thinner over time
- Images of men have become more muscular over time
- This comparison highlights the unrealistic beauty standards present in media
TREATMENT APPROACHES

Eating Disorder Treatment Team
- Psychologist: Intake assessment; psychotherapy
- Dietitian: nutritional counseling
- Primary Care Provider: medical management
- Psychiatry: medication management
- Parents and Child/Adolescent

Nutritional Counseling
- Establishes goal weight based on growth charts
- Established meal plan
- Monitors weight
- Teaches parent and patient about feeding relationship
- Teaches normal eating vs. dysfunctional eating

Prochaska Stages of Change

Stage I: Precontemplative

Patient Characteristics:
- Eating disorder is a solution to a problem
- Impaired cognitive functioning
- Angry with parents for "overreacting"
- Low motivation for change
- Resistant to therapist and counseling sessions

Treatment Goals:
- Psychoeducation
- Inventory of impairment
- Develop rapport is key
- Medical stability
**Stage II: Contemplative**

**Patient characteristics**
- Sees damage of ED
- Emotions are volatile,
- Honesty is difficult
- Relationship with therapist improves
- Patient angry about meal plan and restrictions,

**Treatment Goals**
- Increase awareness of ED impact on individual/family
- Anxiety management
- Emotional awareness
- Narrative therapy approach;
- Increase support

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**Normal Eating versus Dysfunctional Eating**

**Normal Eating**
- Three meals and 1-3 snacks at regular times of the day
- Eating regulated by hunger; results in satisfaction
- Eating for nourishment, energy, pleasure and social
- Eating enhances feelings of well being

**Dysfunctional Eating**
- Skips meals, fasts, overeats, diets, chaotic eating
- Eating by “will power”
- Eating to shape body, comfort self or numb pain
- Eating triggers guilt, shame, insatiable desire for more

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**Stage III: Preparation**

**Patient Characteristics:**
- Patient ready to take action
- Patient angry toward ED
- Patient struggles with meal plan compliance

**Treatment Goals:**
- Recognized trigger
- Identify eating disorder story
- Teach redirection and self-soothing behaviors

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**Eating Disorder Cycle**

**Binge Eating Cycle**

- Drive for Thinness
- Restrict
- Hunger
- Shame
- Pursuit Of Thinness
- Guilt
- Binge
- Purge
- Excessive Exercise
- Disrupted Eating
- Unhealthy Body Image

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1999 Institute for Research and Education Health System Minnesota
Stage IV: Action

Patient characteristics
- Symptom reduction
- Motivated is strong
- Relationships outweigh ED
- Reduced symptoms
- Desire for balanced life

Treatment Goals
- CBT strategies
- Body image work
- Assertive expression
- Stress management
- Conflict resolution skills
- Teach media literacy

Stage V: Maintenance

Patient Characteristics
- Symptom remission
- Weight goals reached
- Normal eating
- Anxiety/mood improved
- Patient eager to live life

Treatment Goals:
- Recognize relapse
- Relapse management
- Skills review
- Supportive relationships
- Plan for termination

Cognitive Behavioral Therapy

- Eating Disorder Thoughts
- Challenge it
- Focus on the Facts
- Chose healthy behavior
- Change it

Parent and Family Challenges

- Problem: Burn-out and feeling stressed
  - Solution: Self-care, friends, hobbies, relaxation
- Problem: Marital/relationship strain
  - Solution: Date time, eating disorder free conversation
- Problem: Unhealthy coping (drinking, isolation)
  - Solution: Parent/Individual counseling,

Factors Associated with Protracted Treatment

- A long duration of illness prior to the start of treatment
- Severity of weight loss
- Self-induced vomiting and purging behavior
- Difficulty gaining weight within treatment
- Comorbid diagnoses: OCD, Major Depression, PTSD
- High psychosocial stressors/ ACE’s

CHILDHOOD EATING DISTURBANCE

Leak & Bryant-Waugh 2000; Anorexia Nervosa & Related Eating Disorders in Childhood and Adolescence
Normal Feeding Problems: Birth to Adolescence

- Infancy feeding difficulties, colic and weaning problems are common
- Preschool children are selective with new tastes and textures; food jagging
- Maturation lessen and can resolve
- Parents can make these issues worse with poor meal structure and over control at mealtime

Satter, Ellen; 2005 Your Child's Weight Helping Without Hurting

Avoidant/Restrictive Food Intake Disorder

- Eating and feeding disturbance including lack of interest and avoidance based on the sensory characteristics and concern about aversive consequences of eating.
- Persistent failure to meet appropriate nutritional and or energy needs
  1. Significant weight loss (failure to achieve expected weight gain or faltering growth
  2. Significant nutritional deficiency
  3. Dependence on enteral feeding or oral nutritional supplements
  4. Marked interference with psychosocial functioning.
- Weight loss not explained by lack of food or culturally sanctioned practice
- Illness does not occur exclusively during the course of AN or BN, no body image disturbance
- No current medical condition or other mental disorder explains condition

Treatment Modalities

- Psychotherapy for parent and child
- Nutritional counseling with dietitian
- Occupational therapy for implementation of feeding protocol
- Psychiatry consultation as needed for medication management
- Primary Care medical care or medication management

Case Example

- 10 year old girl with Autism
- Developed gastrointestinal illness with persistent vomiting
- Sensitive stomach persisted with GERD
- Refeeding stalled
- Significant weight loss
- Fear of vomiting and pain; high anxiety
- Increased selective/restrictive food choices
- Resolved with 4-6 months of exposure; soft food diet to increasingly challenging foods
- Eliminated unusual behavior (e.g., tearing food apart)
Case Example

- 12-year old boy with identical twin
- Ate variety, very low volume and appetite
- Small compared to brother who ate well
- Child history of anxiety
- Wanted to eat normally and wanted to grow
- History of parental coercion at mealtime
- Treated physical symptoms of anxiety with relaxation training and biofeedback
- Referred to OT

Functional Dysphagia (Specific Phobias)

- Food avoidance with often a clear precipitating event such as choking, unexpected vomiting in public or diarrhea
- Event triggers fear of swallowing, choking or vomiting
- Weight loss over time
- Cognitive Behavioral Therapy; specifically exposure therapy, resolves difficulty with high degree of parental involvement

Case Examples

- Vomiting Phobia
  - 9-year old girl with previous history of anxiety and mild OCD behaviors
  - Stomach flu at home; last of four siblings to get ill
  - Vomited at school
- Choking Phobia
  - 10-year old boy
  - Witnessed choking episode
  - Specific fear of eating in cafeteria
  - Graded exposure

Vomiting Phobia Hierarchy

- Child pretend to vomit
- Watch video of vomiting
- Look at vomit pictures
- Listen to vomit sounds
- Look at cartoon vomit
- Say the vomit words

Importance of Prevention

- Target a large audience
- Decrease the vulnerability of individuals
- Studies show less than 30% of individuals who meet the criteria for an eating disorder diagnosis receive treatment
- Only 40-60% of patients go into complete recovery
- 30% will relapse; 30% chronic course

PREVENTION STRATEGIES

National Eating Disorder Information Center NEDIC
Drive for Thinness Prevention
- Break the link between self-worth and body size and shape
- Promote body acceptance; bodies come in all shapes and sizes
- Decrease emphasis on appearance
- Emphasize the importance of individuality and personal characteristics
- Educate regarding diet industry; people spent 40 billion on dieting products in 1998

Body Dissatisfaction Prevention
- Teach media literacy
- Teach body acceptance skills
- Teach self-esteem enhancing activities
- Teach stress and coping skills
- Educate regarding negative messages women receive daily
- Teach about weightism, the last frontier of prejudice

Early Dieting Prevention
- Educate regarding the dangers of dieting
- 98% of diets fail to provide permanent weight loss
- Teach set point: the body's regulation and defense of natural body weight
- Emphasize fun active life style instead of gym work outs
- Discuss healthy weight management strategies
- Teach peer pressure resistance

Primary Care Prevention
- Psychoeducation at the sports physical re: energy needs
- Growth chart review
- Support through challenges of growth/puberty for girls
- Ask about eating habits (24-hour recall); and exercise
- Encourage family meals
- Provide information regarding healthy family eating habits
- Watch for the Female Athlete Triad

Website Resources
1. ANAD National Association of Anorexia Nervosa and Associated Disorders www.anad.org
2. Eating Disorder Awareness and Prevention www.edap.org
3. OA www.overeatersanonymous.org
4. Female Athlete Triad www.femaleathletetriad.org
5. Academy for Eating Disorders www.aedweb.org
6. BEDA Binge Eating Disorder Association www.bedaonline.com
7. Eating DisordersAnonymous www.eatingdisordersanonymous.org
8. Mindfulness Bell

Eating Disorder Apps
- Recovery Record
- OneRecovery Meeting Finder
- Body Beautiful
- Optimism
- Positive Thinking
- iCounselor: Eating Disorder
- Perfect Diet Tracker
- Cognitive Diary CBT Self-Help
- Cognitive Diary CBT Self-Help
- Eating Disorder Assessments
- Mindfulness Bell
Selected References

- Fairburn (2007): Cognitive Behavioral Therapy and Eating Disorders
- Fairburn (1995): Overcoming Binge Eating
- Satter (2005): Your Child’s Weight; Helping Without Harming

Selected References

- Satter (1987): How to Get Your Child To Eat…But Not Too Much
- Treasure, Smith & Crane (2007): Skills Based Learning for Caring for A Loved One with an Eating Disorder