



The Emily Program

Adolescents & Eating Disorders:
Not Just a Teenage Phase

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Objectives

- Differentiate the 3 primary types of eating disorders
- Identify at least 3 reasons to refer an adolescent to an eating disorder specialist
- Describe 4 levels of interventions for eating disorders
- Name at least 2 ways people outside the eating disorder specialty can support an adolescent in eating disorder treatment

GENERAL STATISTICS

- 20 million women and 10 million men suffer from a clinically significant eating disorder some time in their life
 - This is about 6% of women and about 3% of men
 - *It is also about 8% of adolescent females and 4% of adolescent males*

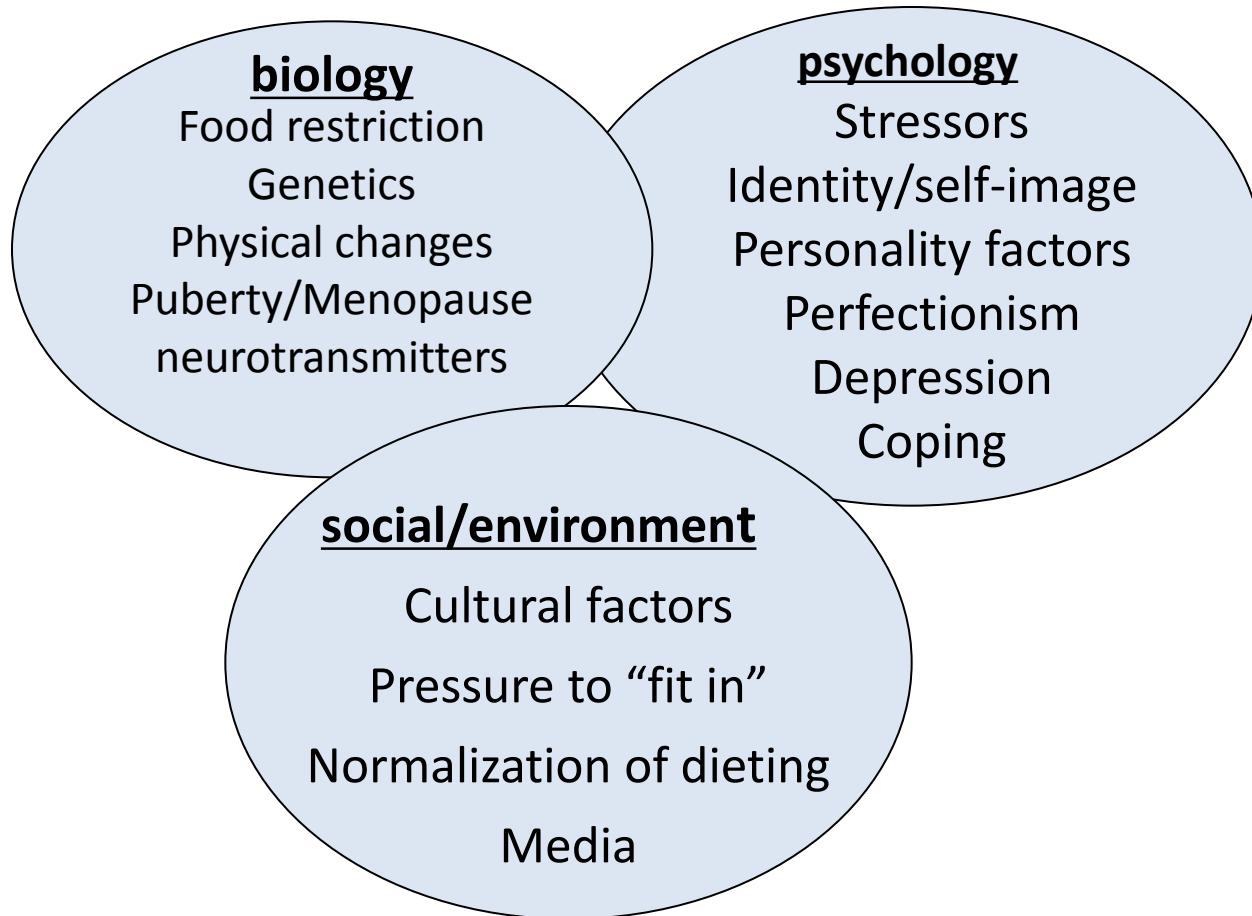
Approximately 50% of adolescents who met full criteria for one of the EDs never talked about their concerns despite having contact with a health care provider. This suggests that prevention and early intervention is critical.

Source: Swanson SA, Crow SJ, Le Grange D, Swendsen J, Merikangas KR. Prevalence and correlates of eating disorders in adolescents. Results from the national comorbidity survey replication adolescent supplement. Arch Gen Psychiatry. 2011 Jul;68(7):714-23.

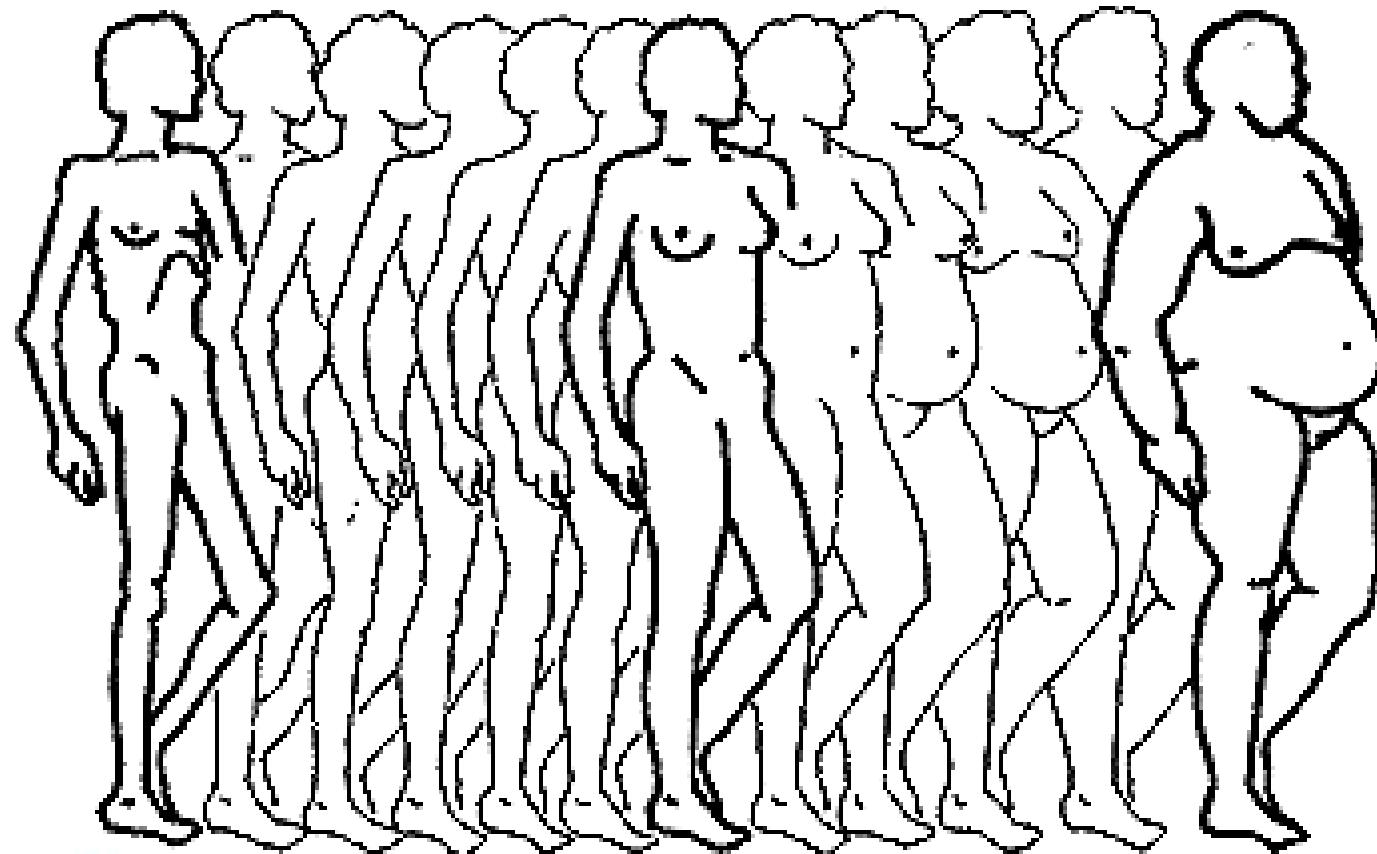
Eating Disorders: Why, who & what?

WHY do people get eating disorders?

Bio-Psychosocial Model of Eating Disorders



WHO: People with eating disorders come in all sizes



Anorexia
nervosa

Bulimia
nervosa

Developmental
obesity

WHAT: Diagnostic Criteria

- **DSM IV**

- Anorexia Nervosa
- Bulimia Nervosa
- Eating Disorder not otherwise specified (ED NOS)
 - Binge Eating Disorder
 - Compulsive Overeating



- **DSM 5**

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Avoidant/Restrictive Food Intake Disorder (ARFID)
- Feeding and Eating Conditions Not Elsewhere Specified (FEC-NEC)
 - Atypical AN
 - Sub BN
 - Sub BED
 - Purging Disorder
 - NES

Anorexia Nervosa

Many people with AN see themselves as overweight, even when they are starved or malnourished. Eating, food, and weight control become obsessions. People with anorexia typically weigh themselves repeatedly, portion food carefully and eat small quantities of a narrow variety of foods.

Anorexia is characterized by

- Relentless pursuit of thinness
- Unwillingness to maintain a healthy weight
- Extremely disturbed body image
- Distortion of body image
- Intense fear of gaining weight

Facts:

Anorexia has a higher mortality rate than any other mental illness. According to the National Institute of Mental Health, people with anorexia are up to 10 times more likely to die as a result of their illness compared to those without anorexia. The most common complications that lead to death are cardiac arrest, and electrolyte/fluid imbalances. Suicide also can result.

DSM-5: Anorexia Nervosa

- A. **Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected.**
- B. **Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.**
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or **persistent lack of recognition** of the seriousness of the current low body weight.

Specify current type:

- Restricting Type: during the last three months, the person has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)
- Binge-Eating/Purging Type: during the last three months, the person has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Bulimia Nervosa

People with bulimia can fall within the normal range for their age and weight, and cannot be identified by their outward appearance. But they often still fear gaining weight, want desperately to lose weight, and are intensely unhappy with their body size and shape.

Bulimia nervosa is characterized by recurrent and frequent episodes of eating unusually large amounts of food, and feeling a lack of control over the eating. This is followed by behaviors that compensate for the eating binge, such as purging, fasting, laxative abuse, excessive exercise, and/or other behaviors.

People are often secretive with behaviors associated with bulimia nervosa, because it usually accompanied by feelings of disgust or shame.

DSM-5: Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- (1) Eating, in a discrete period of time (for example, within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
- (2) A sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications, fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least **once a week** for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Overeating

Binge-eating disorder (BED): *is characterized by recurrent binge-eating episodes during which a person feels a loss of control over his or her eating. Unlike bulimia, binge-eating episodes are not followed by purging, excessive exercise, fasting, or other behaviors to “compensate” for the binge. They also experience guilt, shame and/or distress about the binge-eating – which in turn can lead to more binge-eating episodes.*

BED and compulsive overeating are more commonly than anorexia and bulimia.

DSM-5: Binge Eating Disorder

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

(1) Eating, in a discrete period of time (for example, within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances

(2) A sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating)

B. The binge-eating episodes are associated with three (or more) of the following:

(1) eating much more rapidly than normal

(2) eating until feeling uncomfortably full

(3) eating large amounts of food when not feeling physically hungry

(4) eating alone because of feeling embarrassed by how much one is eating

(5) feeling disgusted with oneself, depressed, or very guilty afterwards

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for three months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging) and does not occur exclusively during the course Anorexia Nervosa, Bulimia Nervosa, or Avoidant/Restrictive Food Intake Disorder.

DSM-5: Feeding and Eating Conditions Not Elsewhere Classified (FEC-NEC)

- **Atypical Anorexia Nervosa**
 - All of the criteria for Anorexia Nervosa are met, except that, despite significant weight loss, the individual's weight is within or above the normal range.
- **Subthreshold Bulimia Nervosa (low frequency or limited duration)**
 - All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than for 3 months.
- **Subthreshold Binge Eating Disorder (low frequency or limited duration)**
 - All of the criteria for Binge Eating Disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than for 3 months.
- **Purging Disorder**
 - Recurrent purging behavior to influence weight or shape, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, in the absence of binge eating. Self-evaluation is unduly influenced by body shape or weight or there is an intense fear of gaining weight or becoming fat

Identifying Factors for Referring to a Specialist

*When disordered eating
turns into an eating
disorder...*

SIGNS AND SYMPTOMS OF EATING DISORDERS

Eating disorders are marked by extremes related to food, weight, body, size and shape: Extremes in emotions, attitude, behaviors, preoccupation, and motivation.

Physical

- Unusual and rapid weight fluctuations
- Fainting, fatigue, low energy, interrupted sleep
- GI discomfort, dysregulation, bloating
- Dry hands, hair or poor circulation
- Hair loss or development of lanugo
- For females, disruption in menstruation
- Chest pain or heart palpitations

Behavioral

- Dieting or chaotic food intake
- Preoccupation with food, weight, size and shape
- Excessive exercise
- Frequent trips to the bathroom
- Change in clothing style (sometimes to hide or to flaunt their body)
- Eating alone, isolation, emotional around food/meals

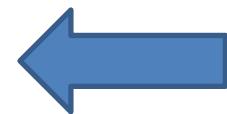
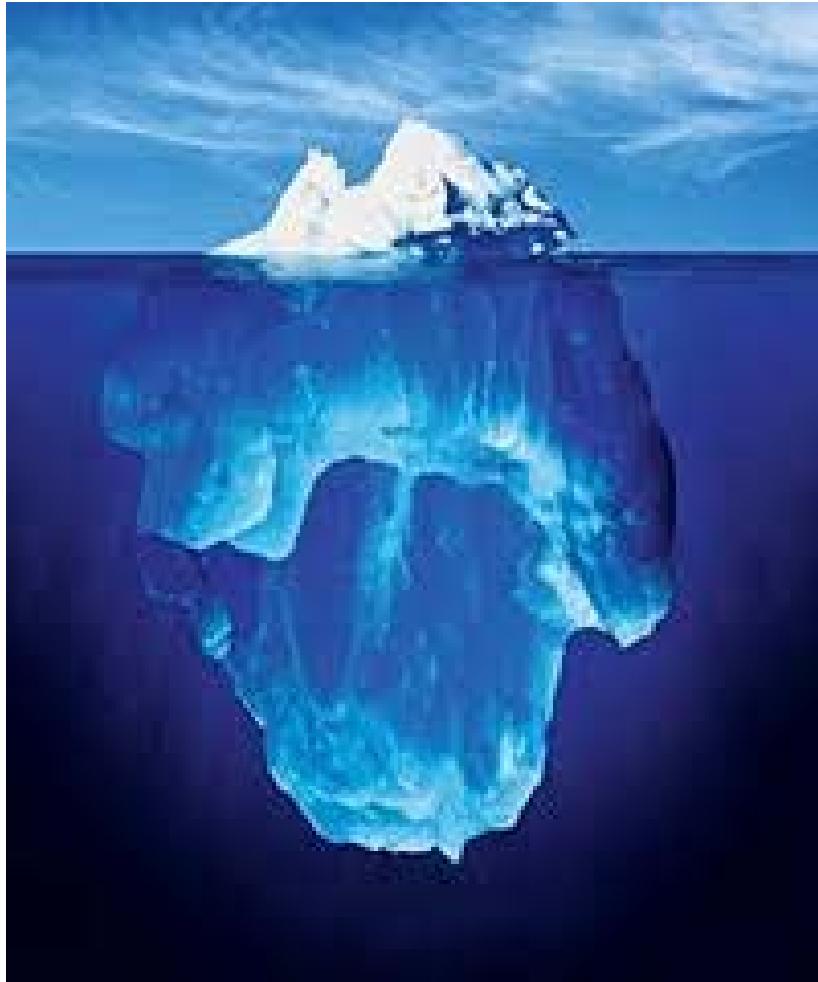
Emotional

- Severe mood swings
- Increased isolation, irritability, anhedonia
- Low self-esteem, complaints about body
- Perfectionistic tendencies
- Sadness or comments about feelings of worthlessness
- Increase of depression, anxiety and/or obsessive compulsive symptoms

When does it become an Eating Disorder?

Key Indicators:

- Is there a pattern of behaviors?
- Is there preoccupation?
- Is there impairment?



Physical signs/behaviors



Mental preoccupation

Behavioral and Emotional Changes

- Over focus on food, body, weight size & shape
- Excessive diet talk/obsession
- Changes in eating patterns, appetite (info may need to come from parents)
- Mood/social changes in combination with above (e.g. depression, anxiety)
- Changes in cognitive processing ability
- Rapid changes in weight

Changes at school

The perfectionistic tendencies of many students with disordered eating may compel them to maintain a high level of performance forcing themselves to stay focused which is even more difficult and taxing given their compromised physical and mental status. They may be able to maintain a semblance of expected performance but with markedly more time and effort required to do so, of which teachers will likely be unaware. Signs can include:

- Avoiding the lunch room and/or frequent requests to use the bathroom and/or frequently coming to class late due to going to the bathroom on the way.
- Classroom behaviors such as short attention span, poor concentration, forgetfulness and poor judgment contribute to a decline in written and/or verbal academic performance
- Failure to initiate, persist and complete simple tasks because of decreased ability to listen and process information
- Inflexible thinking, difficulty switching quickly from topic to topic, heightened need for routine and predictability
- Slowed movement and/or general lethargy along with flat affect
- Rapid changes in weight

Physical Changes

More common indicators

- Rapid weight fluctuations
- Significant deviation from weight chart trends
- Bradycardia or EKG changes

Abnormal labs

Eating Disorders: Critical Points for Early Recognition and Medical Risk Management in the care of Individuals with eating Disorders

(Available on Academy for Eating Disorders website: www.aedweb.org)

What Parents Might See

- Isolation, less social activity
- Weight changes
- Skipping meals/making excuses
- Eating alone
- Dieting, increased focus on food, size, weight, shape, body
- Fatigue, mood swings, irritability
- Dizziness, chest pain, coldness, hair loss, bruising, lanugo
- Personality changes
- Gut instinct

Worried about someone?

Start the conversation. If you suspect someone is struggling with eating disorder behaviors, ask if it is okay to discuss his or her eating habits. For example, “I’m concerned about your eating. May we discuss how you typically eat and your relationship with food?”

Ask more questions. These 6 assessment questions can help assess the situation.
(Adapted from the SCOFF Questionnaire by Morgan, Reid & Lacy)

- Do you feel like you sometimes lose or have lost control over how you eat?
- Do you ever make yourself sick because you feel uncomfortably full?
- Do you believe yourself to be fat, even when others say you are too thin?
- Does food or thoughts about food dominate your life?
- Do thoughts about your body or weight dominate your life?
- Have others become worried about your weight and/or eating?

Give feedback. In this informal survey, 2 or more "yes" answers strongly indicate the presence of disordered eating. Refer as needed.

Timely Interventions

- Clients with EDs may not recognize that they are ill and/or they may be ambivalent about accepting treatment. This is a symptom of their illness.
- Parents/guardians are the frontline help-seekers for children and adolescents with EDs. Trust their concerns.
- Help families understand that they did not cause the illness; neither did their child/family member choose to have it. This minimizes undue stigma associated with the disease.
- Monitor physical health including vital signs and laboratory tests.
- Research demonstrates that treatment within 3-5 years of onset is directly related to a higher rate of recovery

Why should you refer to an ED specialist?

- Due to the bio-psycho-social nature, a comprehensive assessment is critical for assessing appropriate intervention
- Generally, those struggling with an ED need a multi-disciplinary team including therapy, nutritional counseling and medical
 - The #1 medicine for treatment is appropriate nutrition and that needs to occur **simultaneously** with therapy
- You can't talk someone out of poor body image
 - Research demonstrates cognitive impairment caused by poor metabolic functioning
- “Waiting” for it to pass or viewing it as attention seeking behavior could cause irreversible damage

Treatment Options & Levels of Care

- Treatment can look a lot of ways:
 - Residential, or 24 hour care
 - Use of multi-disciplinary team including therapist, a dietitian, and a doctor
 - Attending a group for an hour or for most of the day
- Treatment is dependent on what the person needs
- Family involvement in the treatment process is especially important

In Treatment We Are Trying To...

Help Individuals:

- Eat and be active in tune with the body's needs
- Eat when hungry and stop when satisfied
- Eat a variety of foods without fear
- Focus on health
- Appreciate the body
- Think critically about media
- Employ adaptive coping skills

Who does what, when , and how often?

DIETITIAN

- Meal Planning
- Nutrition Education
- Establishment of wt range
- Education regarding physical aspects of ED
- Weight monitoring
- Strategizing food related activities
- Body image
- Teach Coping Skills

THERAPIST

- Assesses/treats symptoms of related diagnoses (anxiety, depression)
- Monitor and address suicidal thoughts/self-injury
- Explore etiology and maintaining factors of ED
- Body image
- Teach coping skills

PHYSICIAN

- Medical monitoring and treatment of medical conditions related to ED
- Medication monitoring
- Weight monitoring
- Education regarding physical aspects of ED

Outpatient

An outpatient treatment team usually consists of an individual/family therapist and a dietitian. Appointments are generally weekly but vary by need. In addition, clients can work with other disciplines including medical, psychiatry, group therapy, and alternative therapies (such as yoga, art therapy, recreational therapy, spiritual services).

Intensive Outpatient Programs (IOP)

IOP provides regular, structured group and individual programming throughout the week with an emphasis on maximum involvement of a support system. IOP clients see an individual therapist and registered dietitian weekly and a physician, as needed. Treatment is usually 3 hours daily, 3-5 days a week and includes group therapy, one supported meal/snack daily, and skills work.

Main IOP Goals:

- A step-up in support for someone needing more intensive help from outpatient to interrupt eating disorder symptoms
- A step-down for those transitioning from a higher level of care

Intensive Day Treatment (IDP) or Partial Hospitalization (PHP)

IDP/PHP provides the highest level of comprehensive outpatient eating disorder treatment, support, and structure for people with any ED diagnosis, and related issues. IDP/PHP can help prevent the need for inpatient hospitalization, which can be costly and disrupt everyday life.

It is usually 6-8 hours daily, meeting 5-7 times per week, to address psychological, nutritional and medical needs, gain new and healthier coping skills, and achieve individual treatment goals.

IDP/PHP's longer treatment day allows for more successful symptom interruption, more frequent intensive group therapy, and greater involvement of your support network. Clients also see an individual therapist, registered dietitian, and medical weekly, and psychiatry as needed.

Residential/Inpatient

Residential and inpatient care is 24/7 support for complete symptom interruption and intervention for medical stability. It includes structured support for eating all meals/snacks while engaging clients in intensive therapy to address underlying concerns. Inpatient care is usually to address medical concerns and averages a length of stay of about 3-14 days. Residential care tends to be longer and is used to implement more reinforced change and averages a length of stay of about 3-6 weeks.

Treatment Specifics for Adolescents

- Needs to be developmentally appropriate for their cognitive level
- Needs to address the largely involuntary and unmotivated context of their position
- Needs to involve family and a designated support system

What does this look like?

- Increased use of behavioral interventions
- Need for multiple modalities
- Emphasis and use of family systems

*How can I support
treatment?*

Reinforce Hope

- Recovery from an eating disorder is possible; people do get better.
 - Recovery is different for everyone
- People can be in treatment for awhile; it takes time. Rarely is treatment a linear progression.
- Even if someone “looks” better it doesn’t mean they really are. You can’t judge recovery based on looks.

Externalize the Eating Disorder

- Behaviors are driven by biological, psychological and social factors. Separate behaviors from the person (without letting go of consequences)
- Acknowledge the socially engrained culture of attention to weight, body and shape: An eating disorder takes it to an extreme level
- No one “chooses” to have any eating disorder,

Rethink Relationships with Food and Body Image

Recommendations on how to help teenagers maintain a healthy lifestyle without increasing risk for an eating disorder from Dianne Neumark-Sztainer PhD, MPH, RD

- Talk less, do more
- Losing weight does not necessarily mean improving health
- Model the behavior
- Encourage family meals and changes to the whole family's diet
- Keep the focus on overall health, not weight
- Ensure the person knows he/she has worth regardless of their weight



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Resources

www.aedweb.org
www.eatingdisorderscoalition.org
www.nationaleatingdisorders.org
www.tcme.org
www.mollykellogg.com
www.about-face.org
www.something-fishy.org

LOCATIONS:
St Paul
St Louis Park
Burnsville
Stillwater
Duluth
Seattle
Spokane