



Children's National.

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

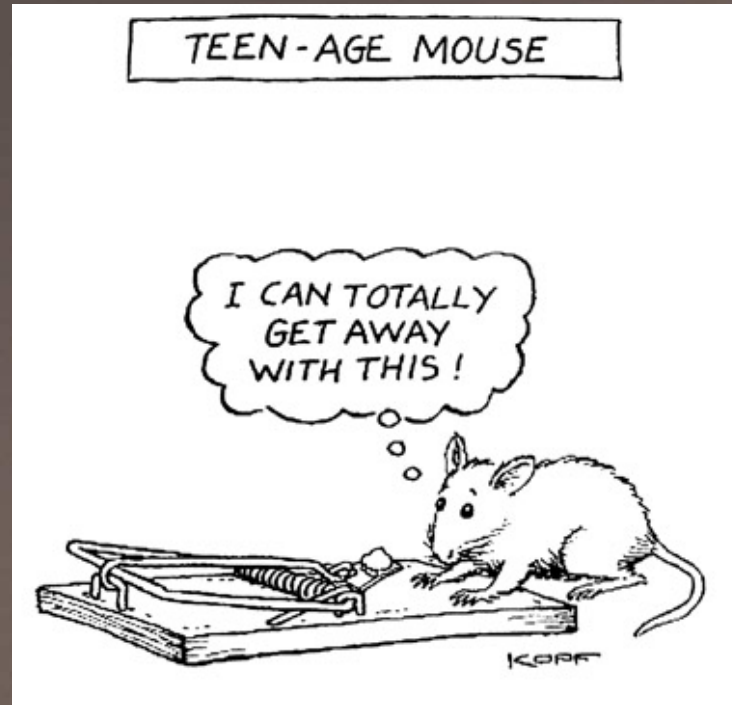
**Patricia Kapunan, MD,MPH**  
**Adolescent & Young Adult Medicine**  
**June 19, 2019**

# Disclosures



I have no conflicts of interest.

# Disclosures



I admit to being an Adolescent Medicine enthusiast.

*If you find interacting with teenagers challenging,  
thank you for participating today.*

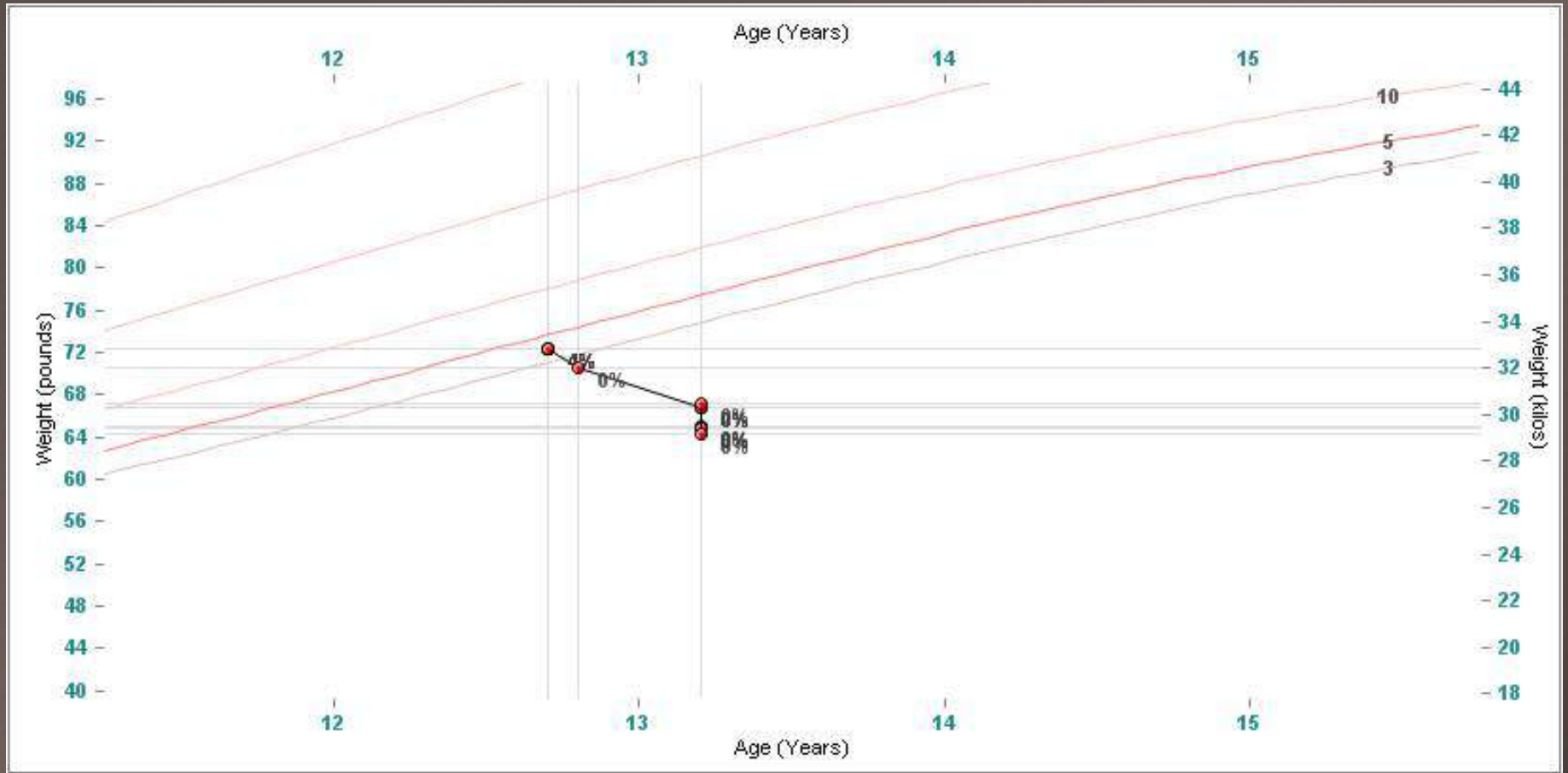
# Learning Objectives

- 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 (OSFEED)

\*Campbell & Peebles (2014). Pediatrics, 134: 582-92.





# When to worry?

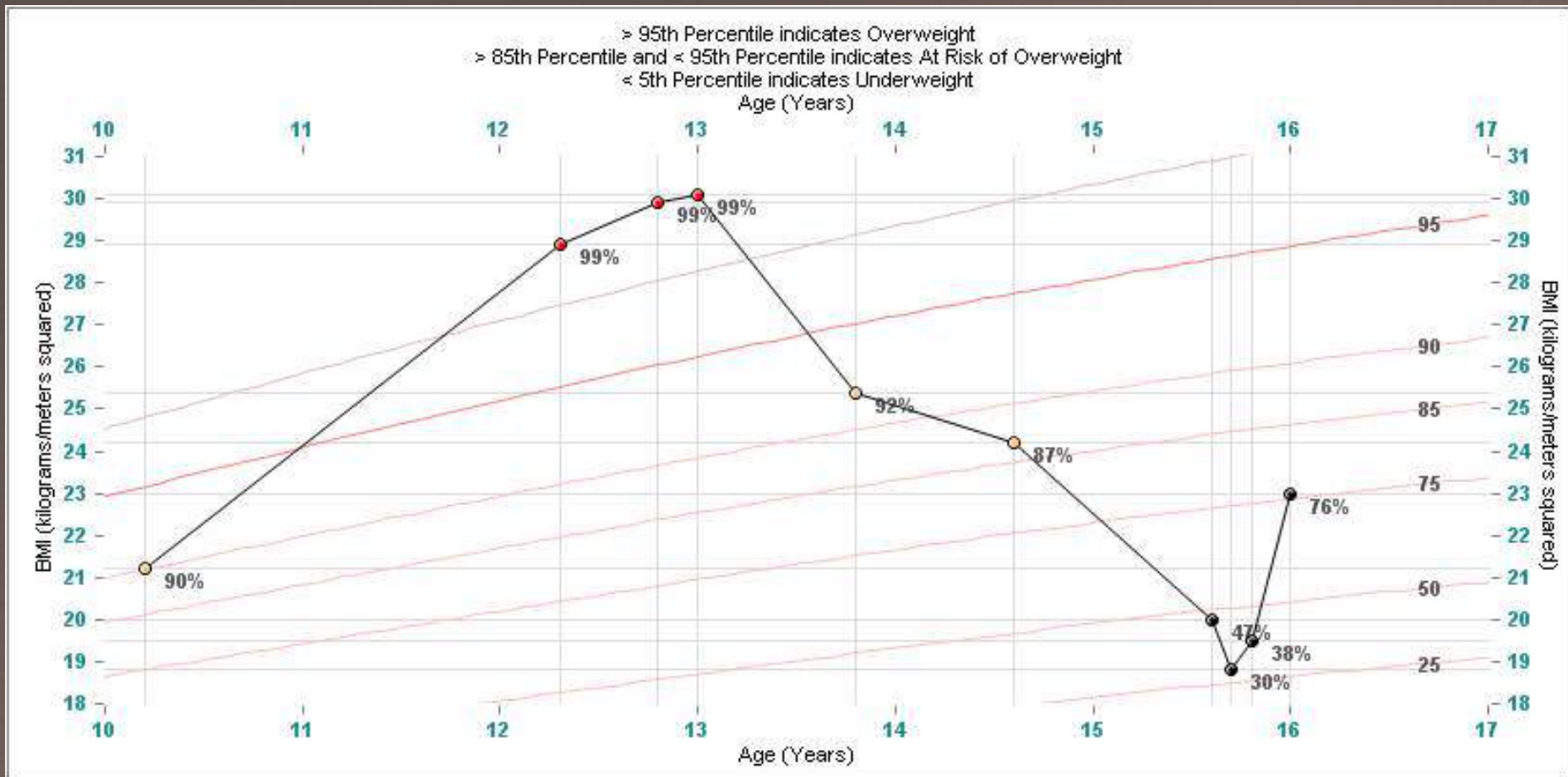
Consider ED in patients with:

- 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
  - Physicals 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

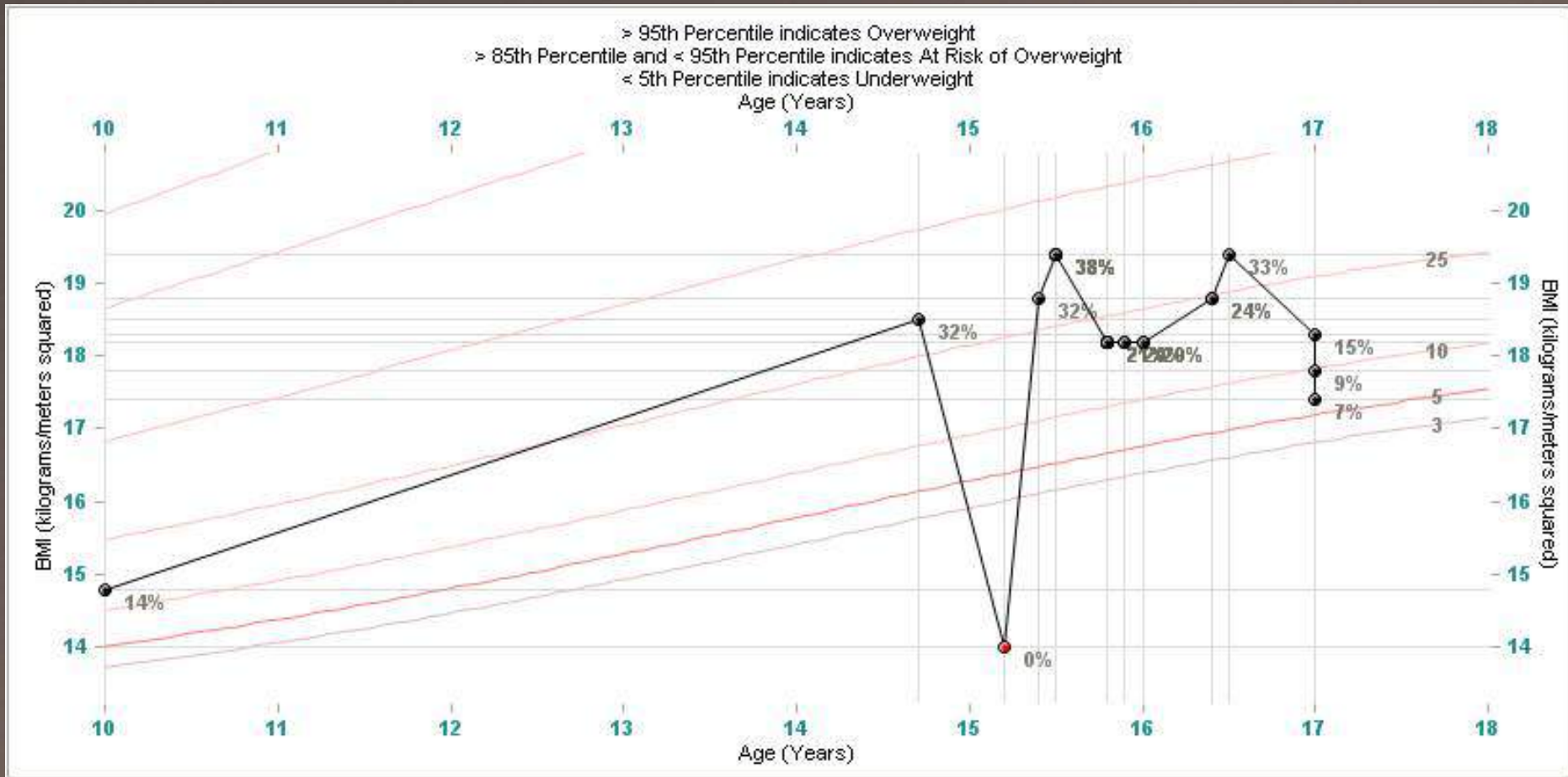
# Levels of Care

## (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 (>20bpm) or hypotension (>10mmHg), or overt syncope

Prolonged QTc or other arrhythmia

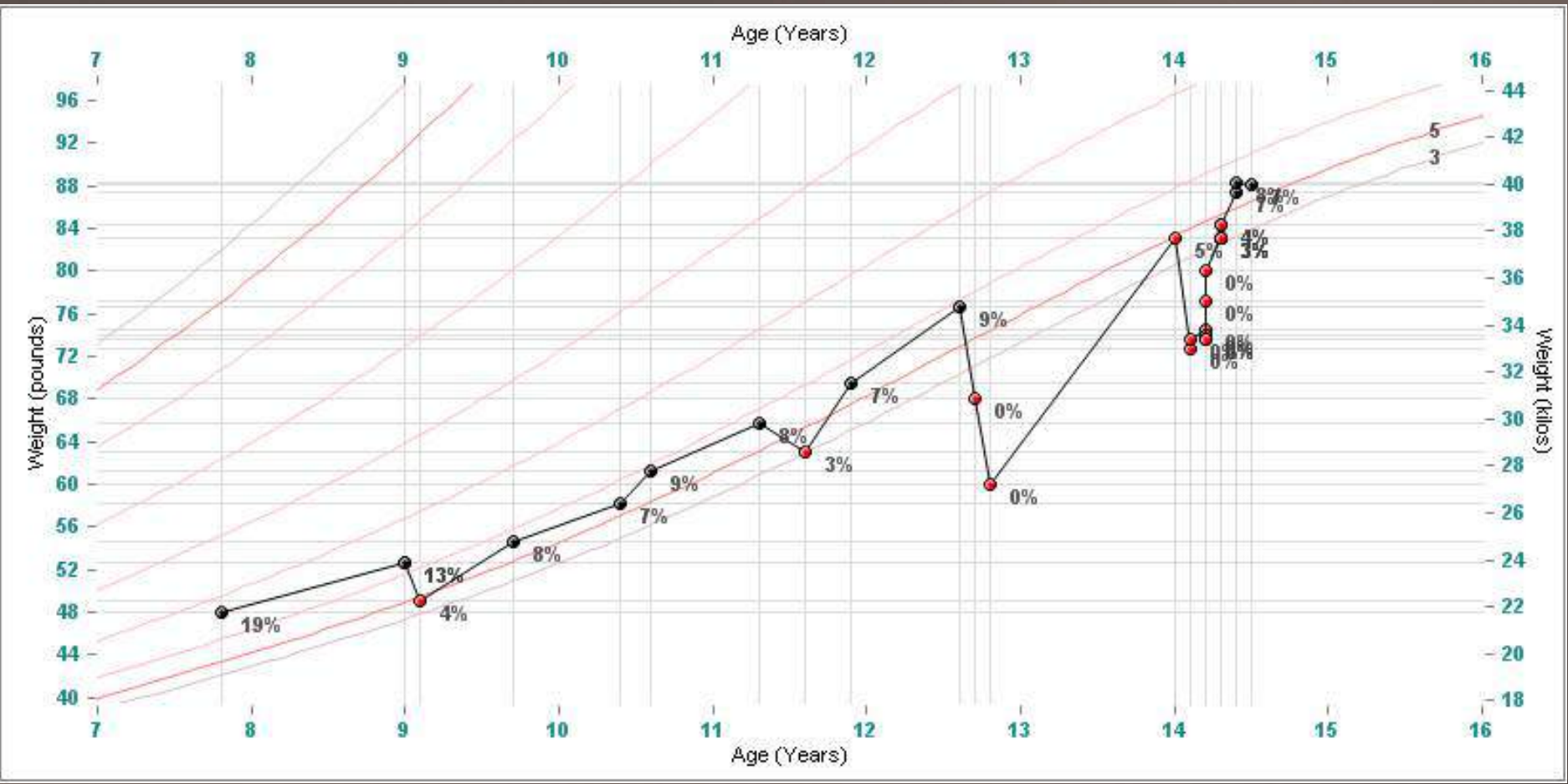
<75% IBW, Body fat <10%

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

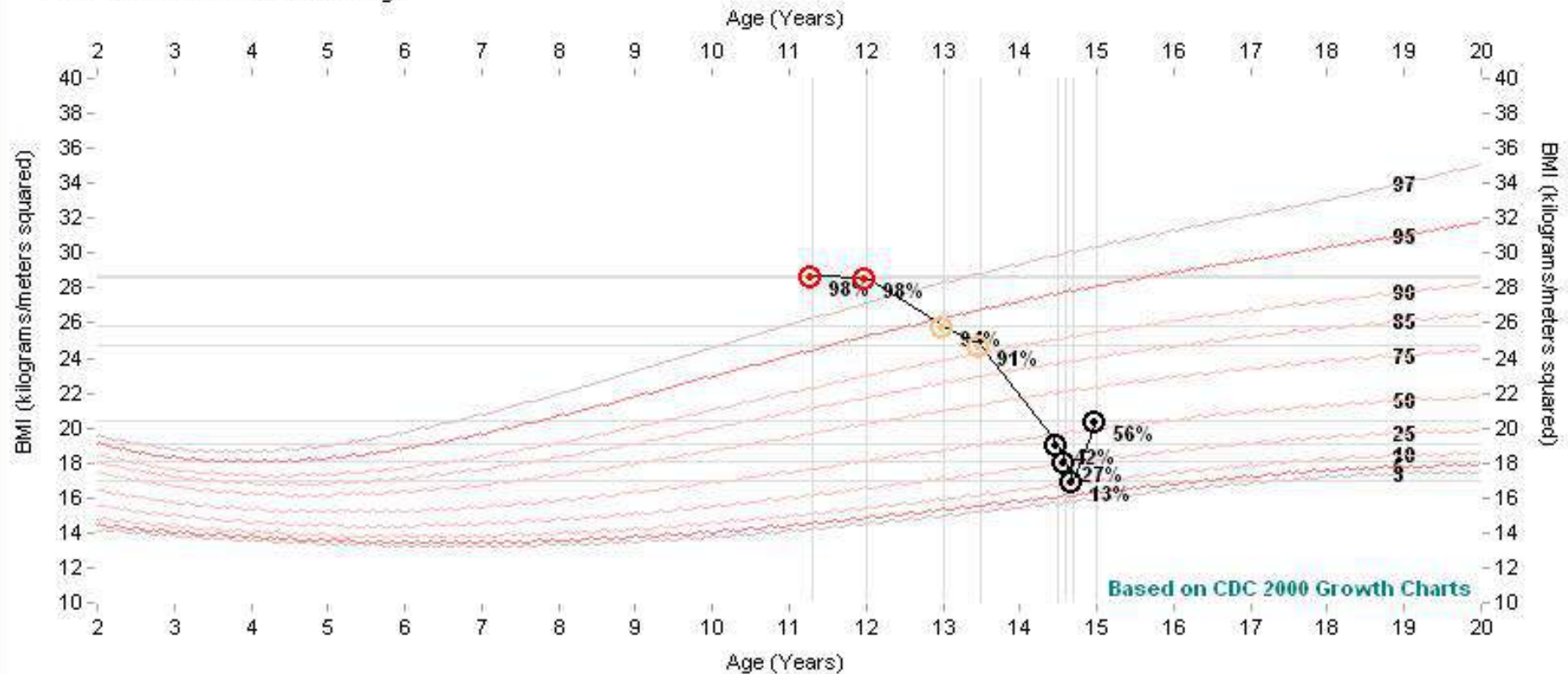
- Packs own lunch
- Outings with friends include snacks/meals

Plans meals, shops/cooks

Adapted with permission from Mulhlheim, L, (2018). *When Your Teen Has an Eating Disorder*. Oakland, CA: New Harbinger.

# Case 5: What does recovery look like?

- > 95th Percentile indicates Overweight
- > 85th Percentile and < 95th Percentile indicates At Risk of Overweight
- < 5th Percentile indicates Underweight



# 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



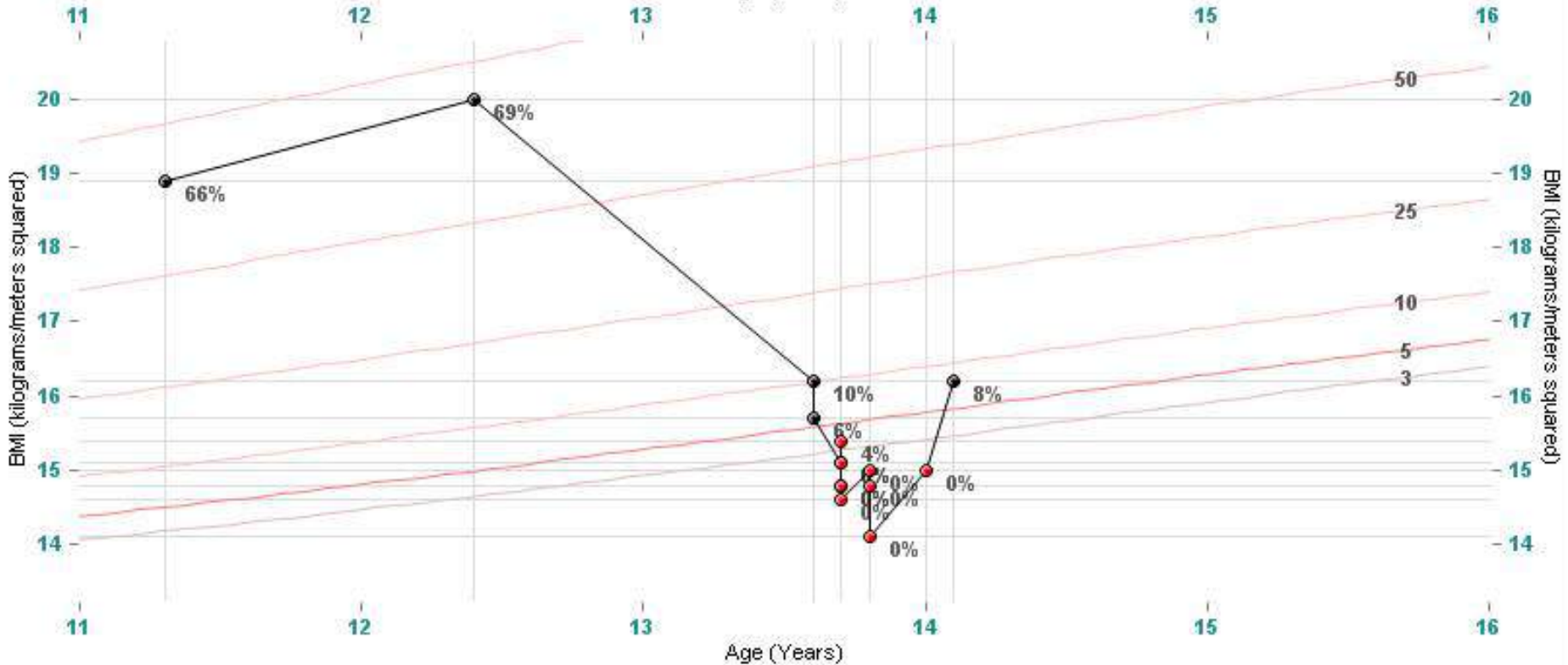
# Recovery Goals

## Psychological

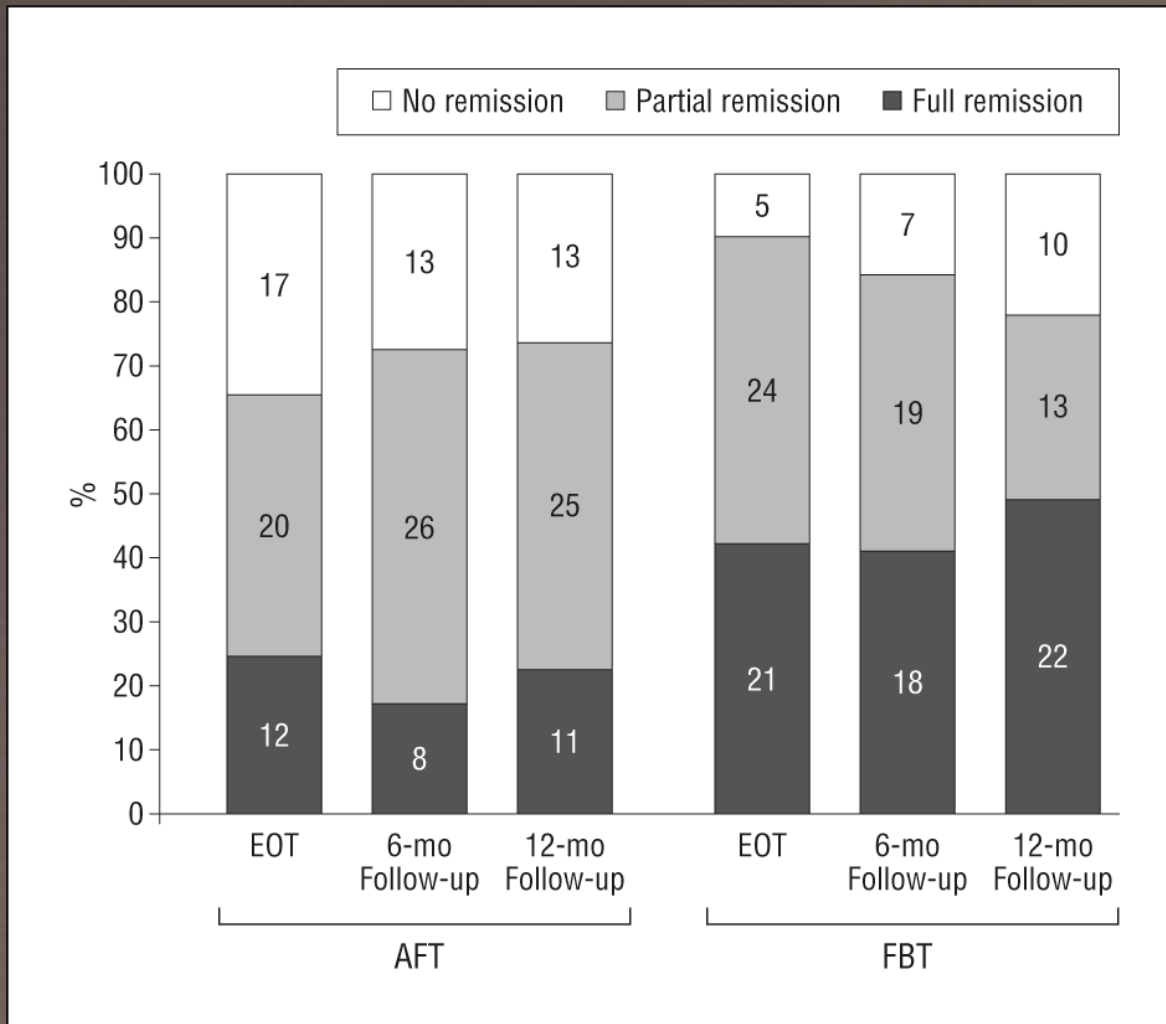
- Decreased influence of body image on self esteem/self concept
- Age appropriate functioning
- Improved social function

# Case 6: What does recovery look like?

> 95th Percentile indicates Overweight  
> 85th Percentile and < 95th Percentile indicates At Risk of Overweight  
< 5th Percentile indicates Underweight  
Age (Years)



# Outcomes



N=121, RCT of FBT vs. AFT, 12-18yo with AN (DSM-IV)  
Lock & LaGrange (201). Arch 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)

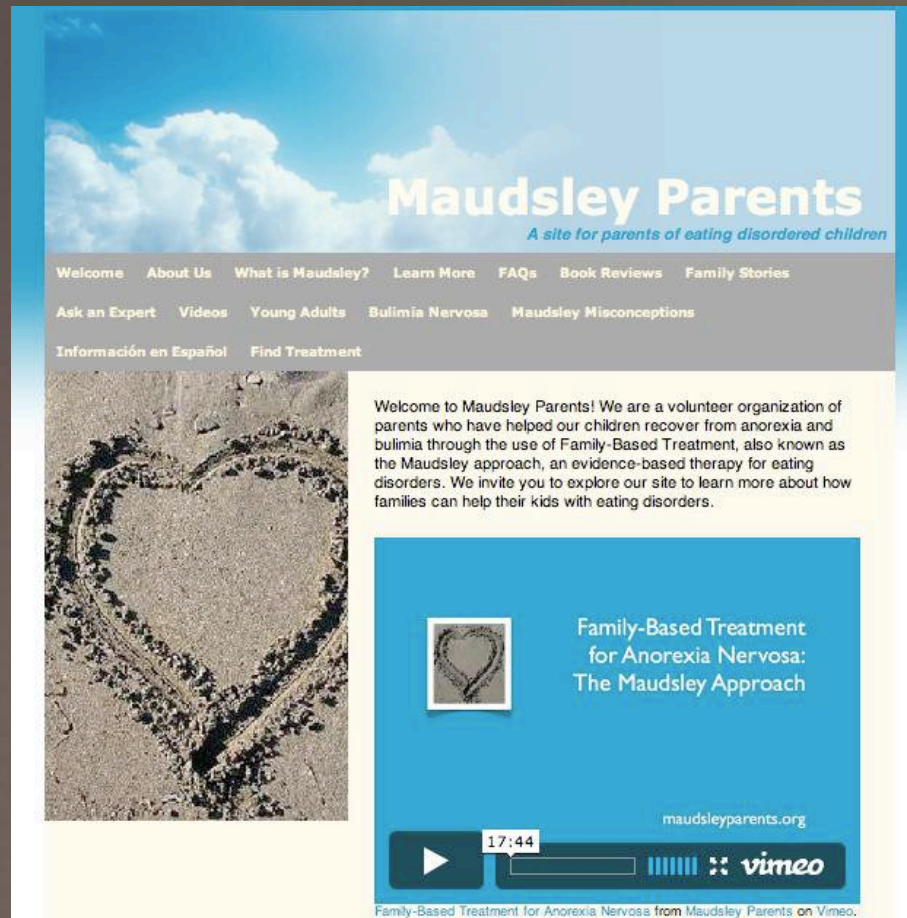
Rome, E & Strandjord, SE (2016). Eating Disorders. *Pediatrics in Review*, 37(8):323-336.

Campbell, K & Peebles, R (2014). Eating Disorders in Children and Adolescents: State of the Art Review. *Pediatrics*, 134(3): 582-6.

Gaudiani, JL (2019). Sick Enough: A Guide to the Medical Complications of Eating Disorders. New York, NY: Routledge.

Shaefer, J (2004). Life Without Ed. New York, NY: McGraw Hill.

# Resources for Families: FBT



**Maudsley Parents**  
*A site for parents of eating disordered children*

Welcome About Us What is Maudsley? Learn More FAQs Book Reviews Family Stories  
Ask an Expert Videos Young Adults Bulimia Nervosa Maudsley Misconceptions  
Información en Español Find Treatment

Welcome to Maudsley Parents! We are a volunteer organization of parents who have helped our children recover from anorexia and bulimia through the use of Family-Based Treatment, also known as the Maudsley approach, an evidence-based therapy for eating disorders. We invite you to explore our site to learn more about how families can help their kids with eating disorders.

Family-Based Treatment for Anorexia Nervosa: The Maudsley Approach

maudsleyparents.org

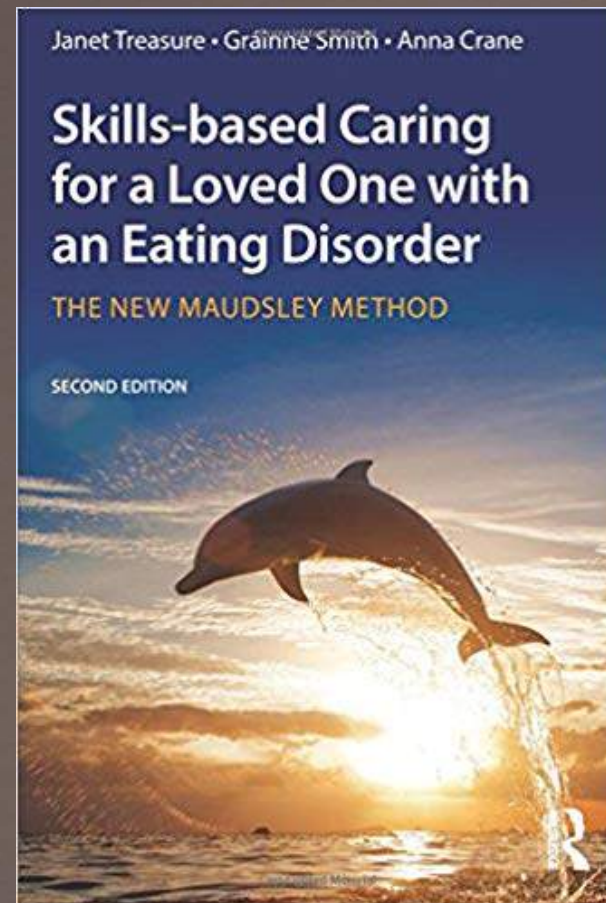
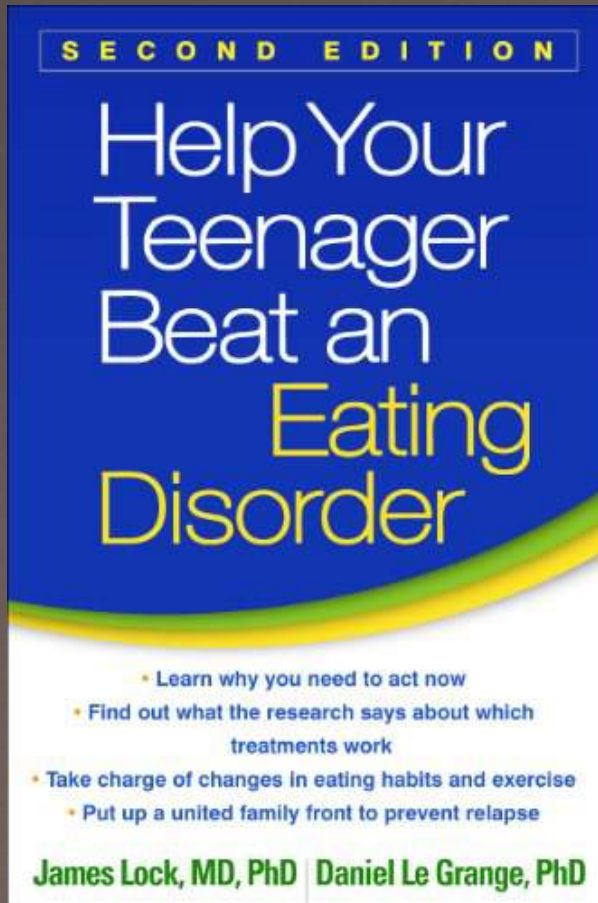
17:44

play button progress bar :: **vimeo**

Family-Based Treatment for Anorexia Nervosa from Maudsley Parents on Vimeo.

[www.maudsleyparents.org](http://www.maudsleyparents.org)

# Resources for Families: FBT



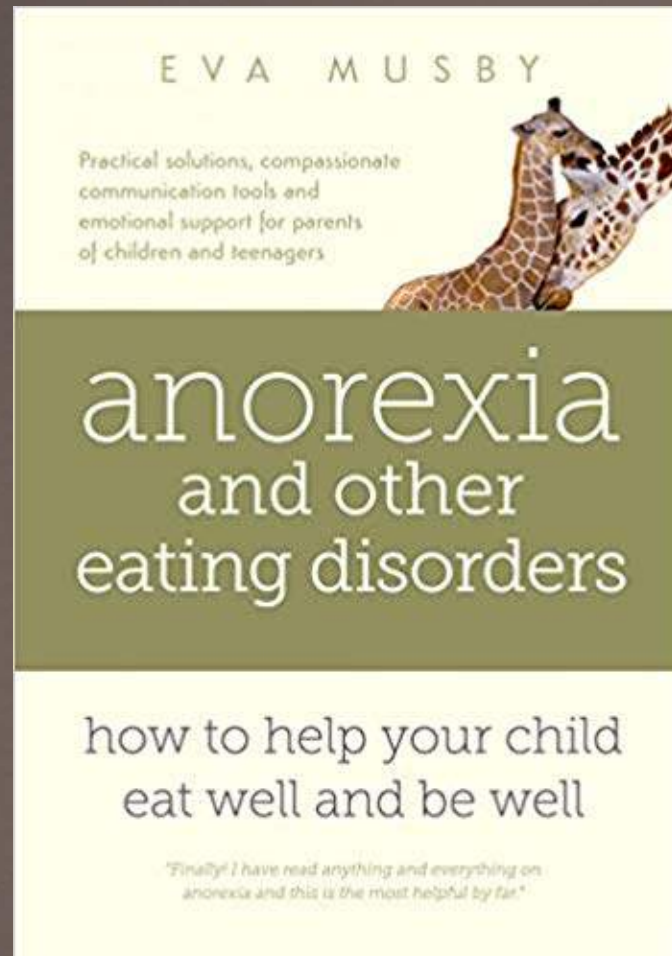
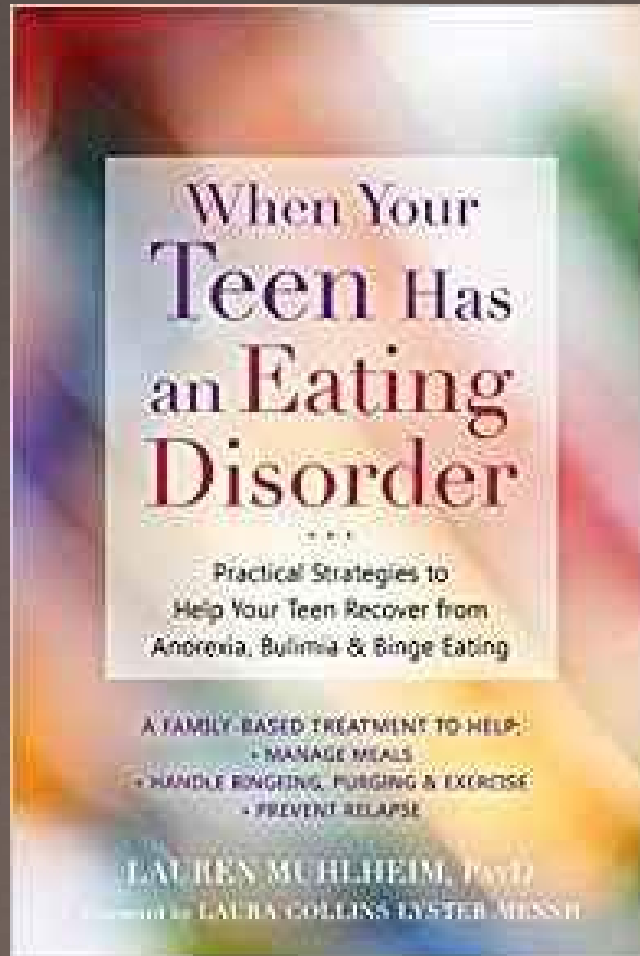
# Resources for Families



The screenshot shows the F.E.A.S.T. website homepage. At the top left is a logo with a stylized orange 'f'. Next to it is the text 'Click Here to Access 24/7 Live Online Forum' with a right-pointing arrow icon. To the right is the acronym 'F.E.A.S.T.' in large orange letters, with the full name '(Families Empowered and Supporting Treatment of Eating Disorders)' below it. A dark blue navigation bar contains the following menu items: 'About FEAST', 'Members', 'Forum', 'Local Support', 'The Facts', 'Treating EDs', and 'Resources'. Below the navigation bar is a search box with the placeholder text 'Search our site' and a 'Find' button. The main content area features a 'NEW CONTENT:' section with three items: 'F.E.A.S.T. Family Guide Series Information Page', '"Puzzling Symptoms" Online Flip Booklet', and 'F.E.A.S.T. January 2013 Newsletter (Join F.E.A.S.T. to get the April 2013 Newsletter!)'. Below this are six icons with corresponding text: a muffin for 'Nourishing Words Blog', a newspaper for 'F.E.A.S.T. News Blog', a 'WELCOME' sign for 'Join F.E.A.S.T.', a hand holding a coin for 'Donate to F.E.A.S.T.', colorful handprints for 'Our Stories', and a stack of books for 'Book Reviews by Caregivers'. At the bottom of this section are two buttons: a green envelope icon for 'Contact F.E.A.S.T.' and a red button for 'F.E.A.S.T. Caregiver Conferences Information, Videos, Reports & Highlights'. A large banner at the bottom of the main content area reads 'Wherever you are in the world of ED treatment... F.E.A.S.T. is here. Families Empowered and Supporting Treatment of Eating Disorders'. On the right side of the page is a 'Quick Links' section titled 'for Getting Started at F.E.A.S.T.' with a list of links: 'For Parents & Caregivers', 'For Treatment Professionals', 'For the Community', 'F.E.A.S.T.'s Services', 'Book Reviews by Parents', '2011 FEAST Conference Videos', 'Calendar', 'Our Principles', and 'What is the ATDT Forum?'.

[www.FEAST-ED.org](http://www.FEAST-ED.org)

# Resources for Families



# Donald Delaney Eating Disorders Clinic at Children's National

- **Clinic Director:**
  - Darlene Atkins, Ph.D., [datkins@cnmc.org](mailto: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](mailto: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

# Acknowledgments

## Team Delaney:

Dr. Darlene Atkins

Dr. Tomas Silber

Dr. Lisa Tuchman

Dr. Larry D'Angelo

Dr. Rebecca Begtrup

Alison Totta, RDN, LDN

Ms. Fairon Fitzhugh

Ms. Petrinia Young

## Main Campus Collaborators:

Dr. Kierre Nelson

Dr. Finza Latif

Aisha Meertins, LICSW





# Discussion



[pkapunan@childrensnational.org](mailto:pkapunan@childrensnational.org)