Presenter:

Edith Nkwenty - (Nurse Practitioner CYMHS Eating Disorders Program)

Eating disorders in children and adolescents.

Q&A

Queensland Government

Children's Health Queensland pays respect to the traditional custodians of the lands on which we walk, work, talk and live.

We also acknowledge and pay our respect to Aboriginal and Torres Strait Islander Elders past, present and future.

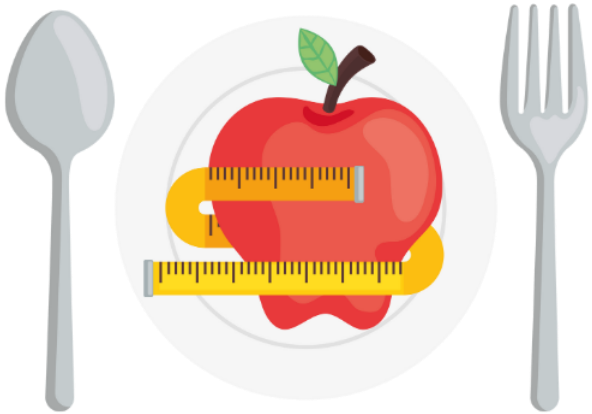
Artwork: concept watercolours of *The Glad Tomorrow 2014-2018* a sculptural installation.
Artist: Tony Albert, Girramay, East Cape region, Kuku Yalanji, East Cape region

A Continuum

"Body image problems and eating disorders sit on a continuum which ranges from

healthy body image and eating patterns through disordered eating and eating behaviours…to… diagnosable clinical eating disorders".

(Paxton, 2011)



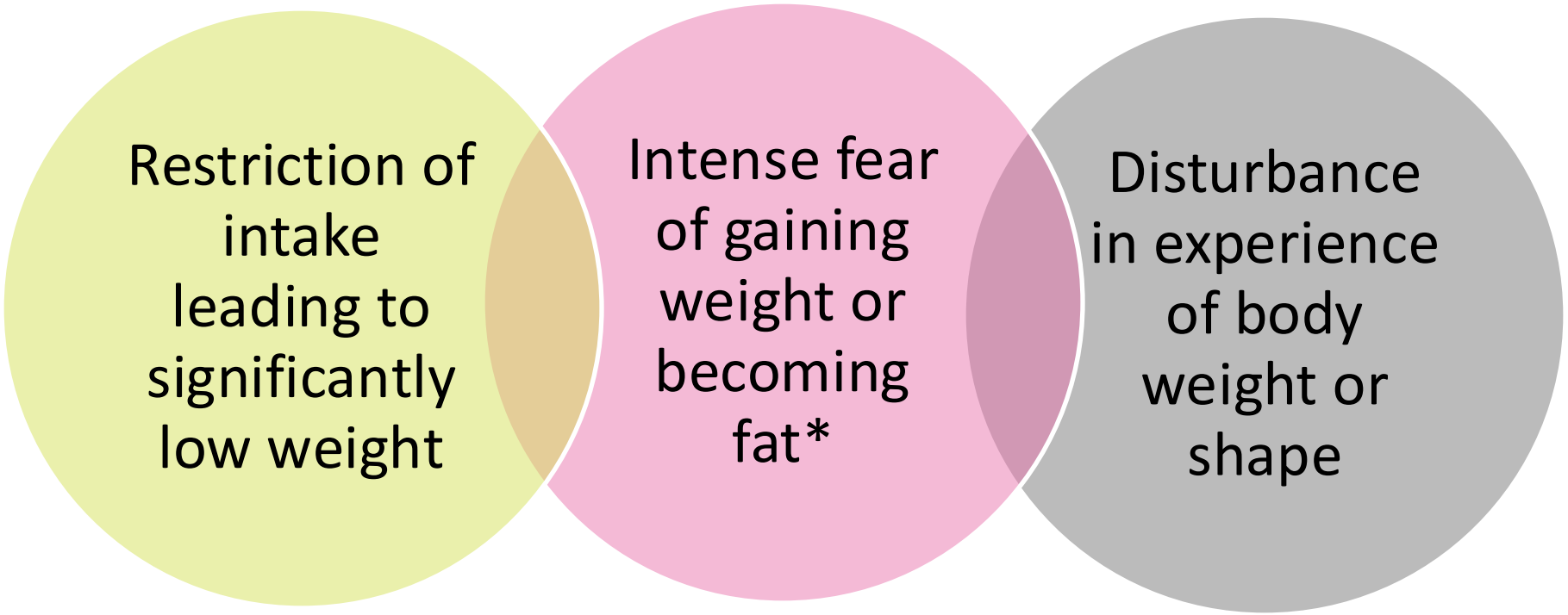
What are Eating Disorders?

- An eating disorder is a serious mental illness characterised by extreme concerns about weight, shape, eating and/or body image.
- These concerns lead to disordered and unhealthy patterns of behaviour, including restricting food intake, fasting, counting calories, vomiting, misuse of laxatives, and excessive or driven exercise.
- These behaviours can greatly affect a person's physical, psychological and social functioning.
- Over 1 million Australians or approximately 4-9% of the population suffer from an eating disorder according to the NEDC.
- Have the highest mortality rate (from medical complications and suicide) of any psychiatric disorder.
- With early appropriate treatment, dedication and hard work, recovery is possible. The sooner treatment is commenced, the greater the chance of a full recovery.

Types of Eating Disorders

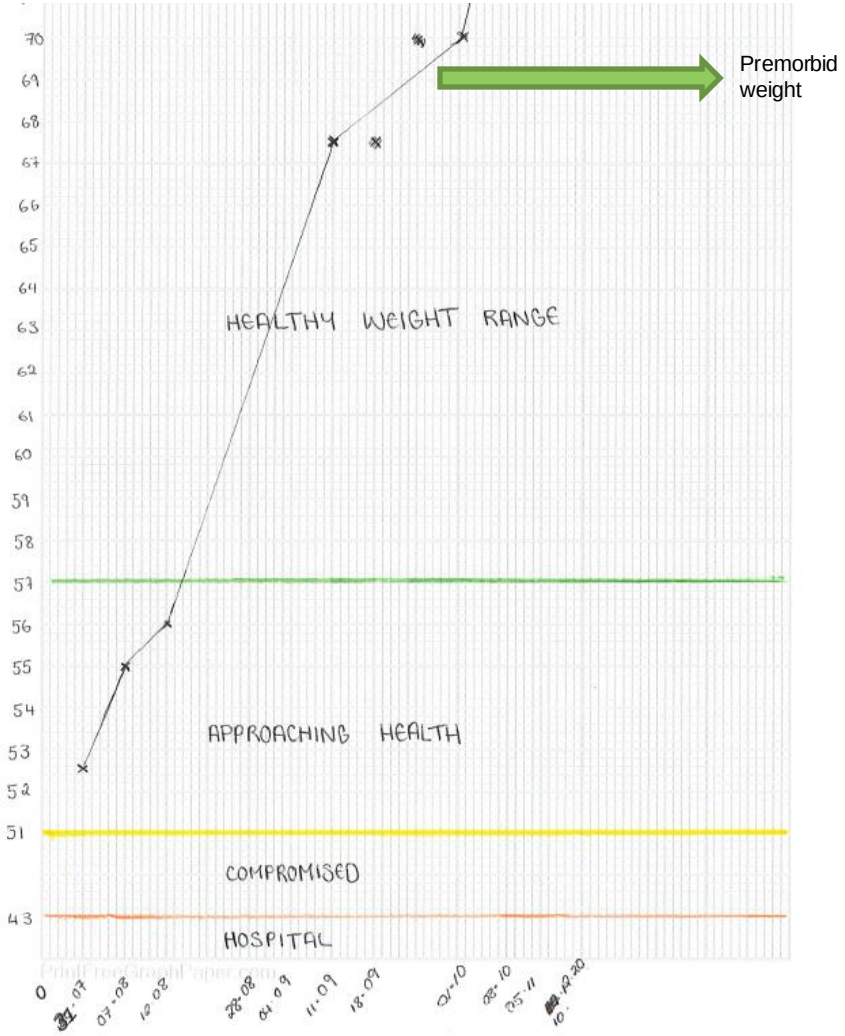
- Anorexia Nervosa and Atypical Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Avoidant/Restrictive Food Intake Disorder (ARFID)
- Other Specified Feeding or Eating Disorder (OSFED) and Unspecified Feeding or Eating Disorder (UFED)

Anorexia Nervosa

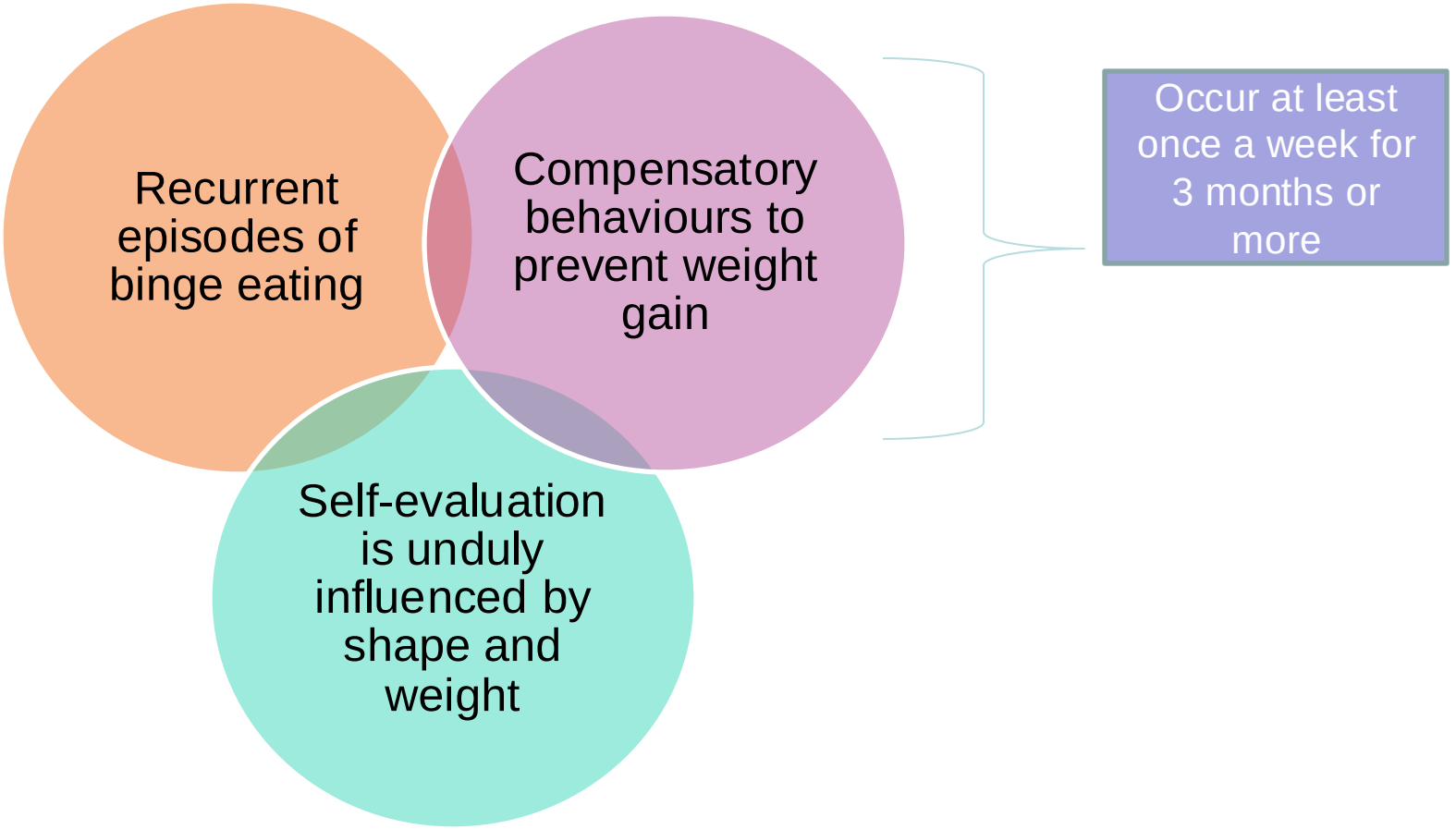


Atypical Anorexia Nervosa

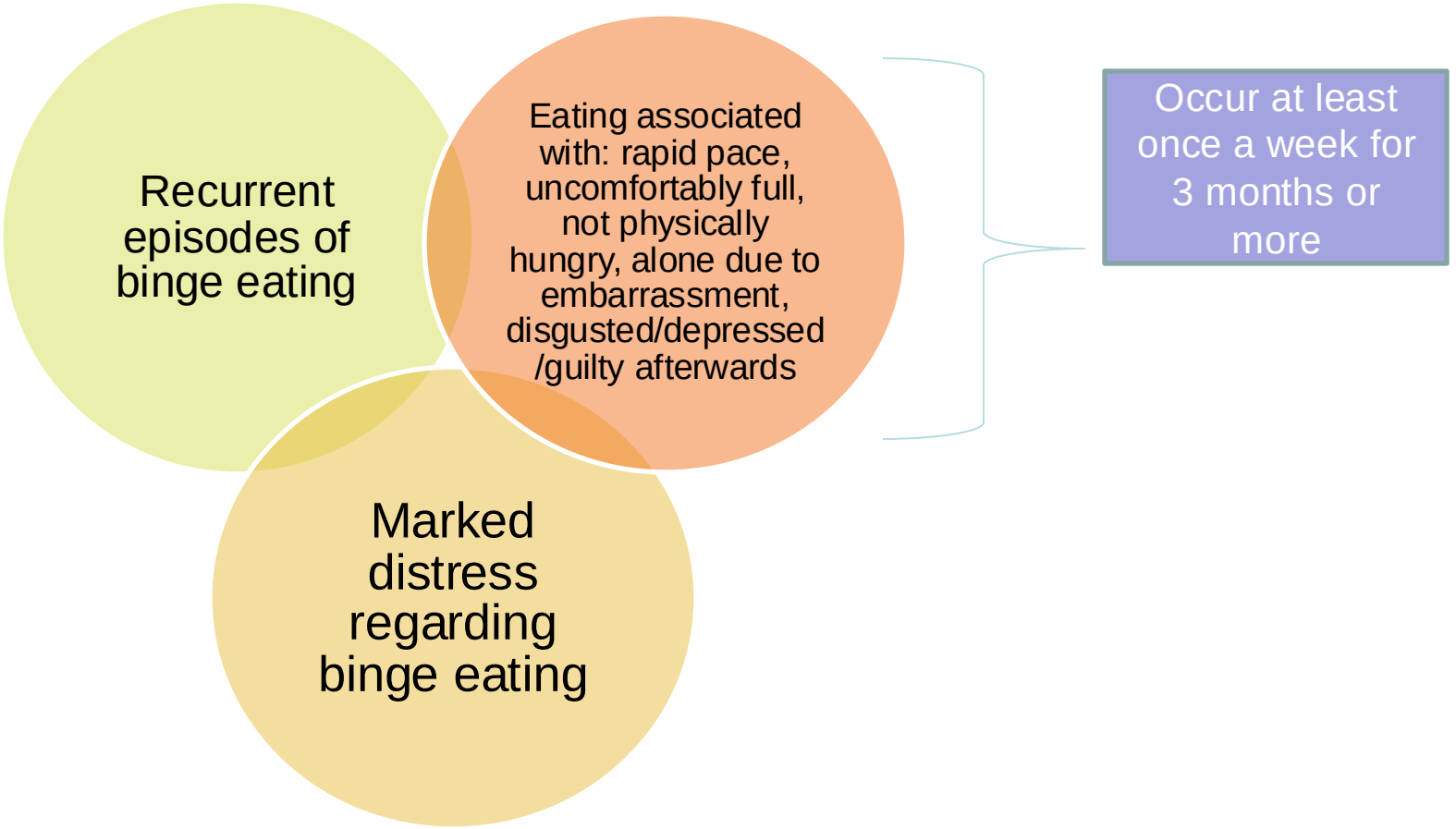
- All criteria for AN are met, except that despite significant weight loss, the individual's weight is within or above the normal range
- Medical compromise and psychological impact can be as severe, if not worse, as it is in typical anorexia nervosa.
- Fivefold increase in admissions of adolescents with AAN over a 6-year period in tertiary Australian children's hospital.



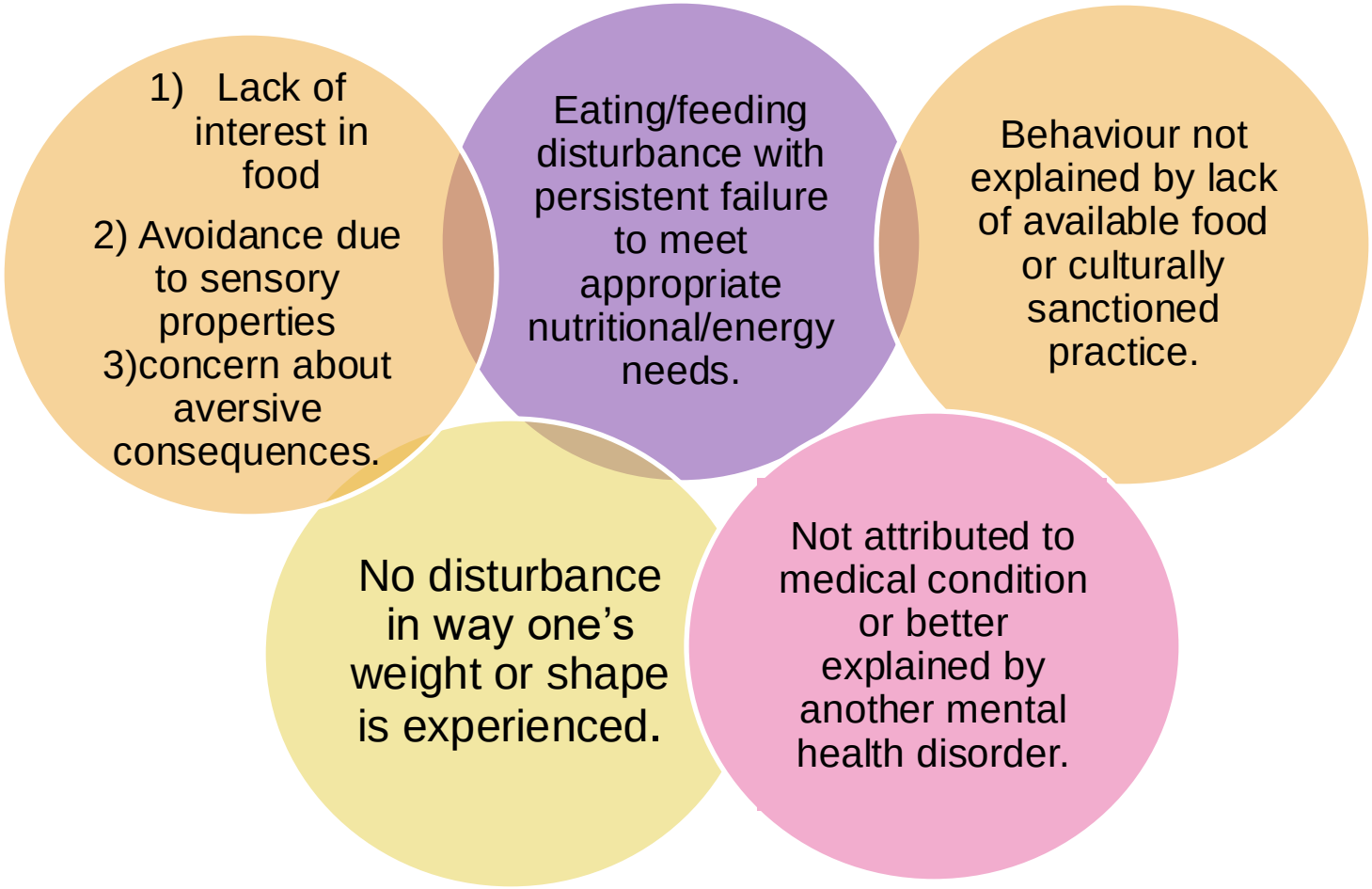
Bulimia Nervosa



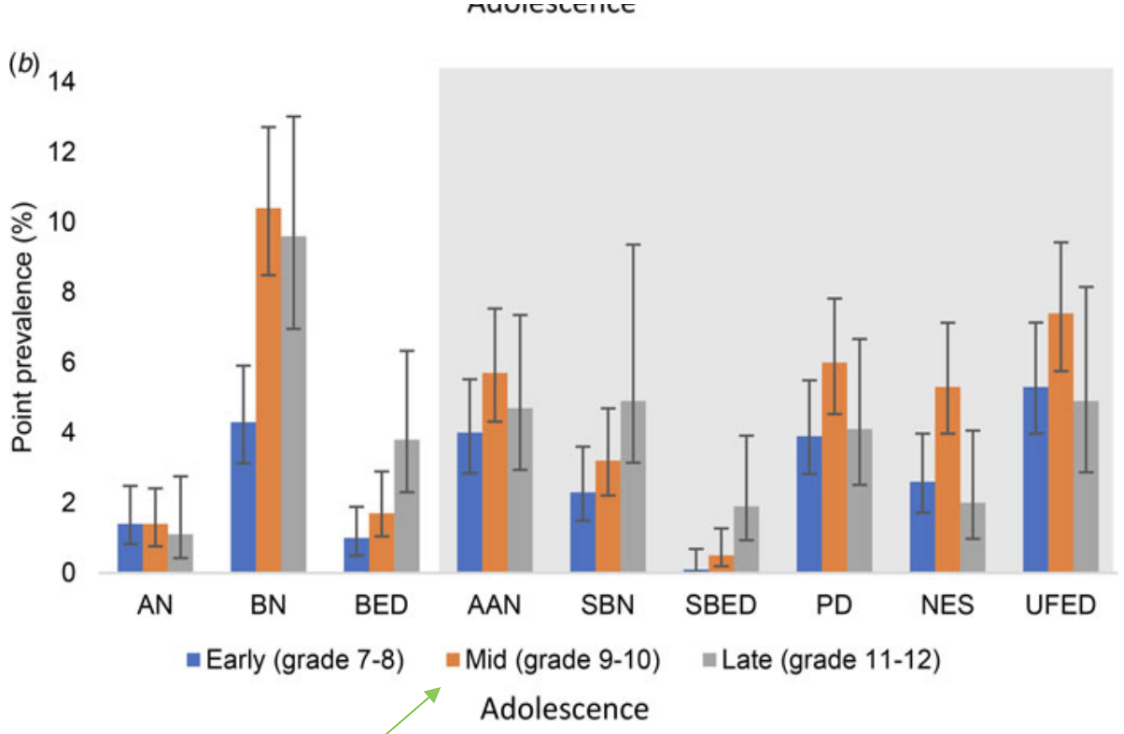
Binge Eating Disorder



Avoidant/Restrictive Food Intake Disorder (ARFID)



Prevalence in Australian Adolescents



Atypical AN

Mitchison et al., 2019

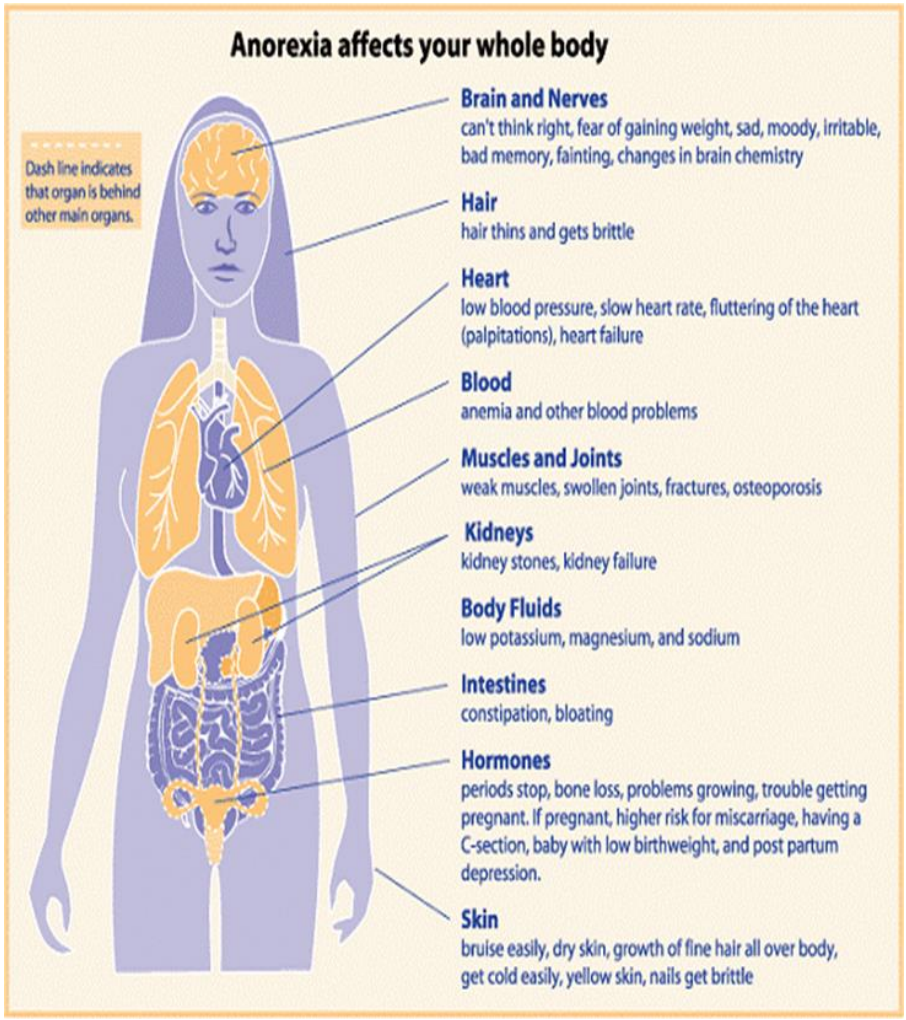
Early signs of an eating disorder

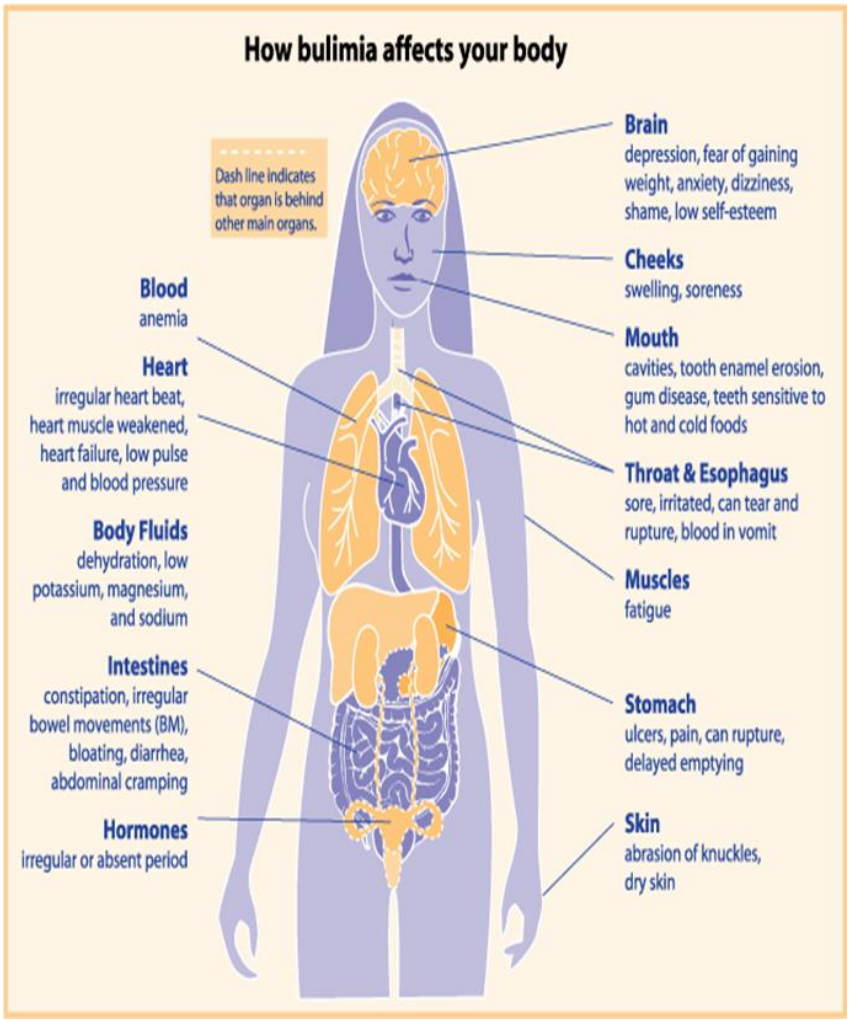
- Disordered eating patterns (not eating as much or as often as usual, isolating themselves at meals or just after, CRASH DIETING etc)
- Mood changes –irritable, depressed, anxious and isolate from peers and family. Siblings may notice before parents
- Unexplained, significant increase in physical activity
- Becoming more concerned about preparation of food and content of meals
- Preoccupied with weight and calories
- Cutting out foods that they used to eat
- Low energy levels
- Dropping of weight (have to buy new clothes)
- Adolescents will often deny symptoms and say they are not afraid to regain weight
- Eating Disorders are often secretive conditions and hard to spot

Behaviours you may come across

- Bargaining
- Minimising
- Guilt/emotional tactics
- Difficulty making decisions
- Checking behaviours (Scales/clothes/mirrors)
- Compensatory behaviours (Purging/exercise/laxatives/diet pills/diuretics)
- Hiding food, wearing less clothing, jiggling legs
- Wearing baggy and very warm clothing due to cold and haemodynamic decompensation
- Behaviours to avoid detection of weight loss (water loading, wearing weights, taking supplements/sugar on finger tips/refusing investigations/minimal/inappropriate clothing for weather)

Physical and Psychological Effects starvation





Medical Monitoring in Community Treatment

- Medical monitoring is a compulsory and essential part of treatment for eating disorders in the community.
- Medical monitoring occurs weekly with the child or adolescent's general practitioner, during the first 6 weeks of engaging with the CYMHS EDP, then as clinically indicated, depending on medical stability and progress with refeeding (where necessary).
- Needs to be set-up preferably prior to community treatment/discharge from hospital to ensure monitoring begins ASAP.
- Collaboration between treating team and client's medical practitioner (usually GP) is essential for treating eating disorders in the community.
- Results of medical monitoring can be used in clinic or therapy sessions to help with psycho-education,, guiding treatment and assessing medical stability.

What are the indications for admission?...
… to reverse the physiological consequences of MALNUTRITION

SHORT TERM- IN HOSPITAL

- Bradycardia
- Hypothermia
- Postural changes in HR and BP
- Electrolyte imbalance
- Hypoglycaemia
- Starvation effects in the brain
- Monitor for re-feeding syndrome
- Commence adequate energy intake to achieve immediate nutritional resuscitation

- Goal is NOT TO CURE ANOREXIA

MEDIUM TO LONG TERM- OUT OF HOSPITAL

- Maintain flexible eating with adequate energy intake
- Restore weight to healthy weight range
- Resolve anorexic cognitions
- Resume menses
- Restore/ maintain bone health
- Identify and treat co-morbid mental health pathologies
- Return to usual school/ academic/ sporting activities

Atypical AN

- How is “Atypical” AN different from “Typical” AN
- What assumptions do you make when seeing these clients?
- What assumptions do other treating team members make when seeing these clients?
- What assumptions do family/carers make when caring for their loved one?
- Look at current evidence around weight loss drive/obesity treatment and its possible impact in treatment of “Atypical” AN cases
- Discuss current evidence in treatment of “Atypical” AN

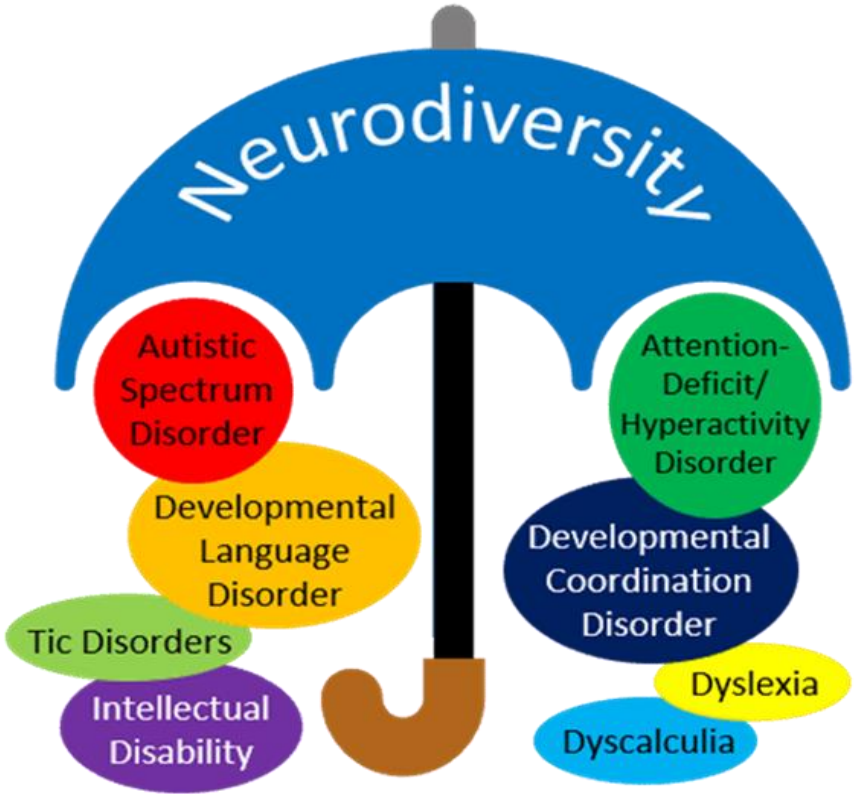
What is “Atypical” AN

- Atypical anorexia nervosa is defined by the DSM-V as an eating disorder wherein “all of the criteria for AN are met, except that **despite significant weight loss, the individual’s weight is within or above the normal range**.”
- What is a person’s “normal weight range”?
- What is “significant weight loss”?
- DSM-V currently recommends an absolute low weight cut-off for children and adolescents to define typical anorexia nervosa as a weight at less than the 5th BMI centile.
- In comparison, the adult criteria of BMI <18.5 correlates with weights that would fall between the 10th and 25th percentiles using CDC 2 to 20 years charts as per patients age.

Cont…

- One size does fit all approach should be avoided
- For example:
  - A 16-year-old girl with a slight premorbid body frame and a lean family body type may not need to weight restore to the 50th percentile
  - While a similarly aged girl, who was in a larger body as a child and comes from a family with many high-weight members, may need to weight restore well beyond that the 50th percentile to achieve full recovery
- We must also not allow our own weight bias to prevent us from advocating for sufficient weight restoration in treatment.

Building competency in working with patients/clients that are neurodivergent



Neurodiversity and eating disorders:

- Assessments and treatments must identify and address with sensitivity the needs of all individuals presenting in our services.
- There is significant overlap between neurodivergence and eating disorders.
- Research has identified links between EDs and neurodivergent presentations including ADHD, ASD, intellectual disability giftedness and Tourette's Syndrome.
- Distinguishing the effects of starvation from these conditions and adapting subtle differences in treatment approaches is important
- Treatment approaches should take into consideration
  - sensory issues, food sensitivities
  - emotional and
  - communication issues which may impact the interventions we provide.
- ARFID is a common presentation in these individuals.

Things to keep in mind for autistic people with an eating disorder

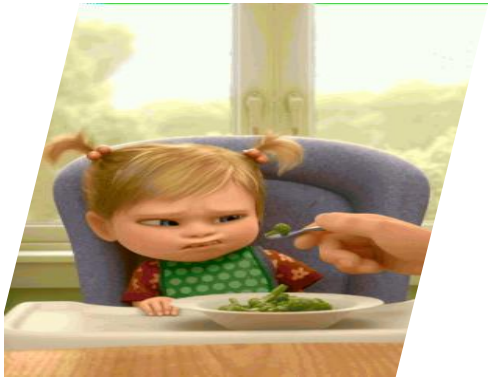
- Distinguishing eating behaviours secondary to ASD vs eating disorder:
- Sensory
- Routines, rituals and resistance to change
- Interoception – not able to identify feelings, pain , hunger cues etc
- Alexithymia:
  - **H**aving difficulty identifying and describing emotions. People with alexithymia may have a hard time pinpointing what emotion they are feeling and communicate emotions to others.
- Communication issues
  - Clarify with the autistic individual that they have understood your communication. Avoid euphemisms or metaphors.
  - Because of poor interoception and alexithymia, they may say they are in pain, but their facial expression may not show that.

A quick word about ADHD and eating disorders

- Prevalence of eating disorders in ADHD sample populations can be as high as 12% (Sobanski 2006)
- 5-17% of eating disorder population samples meet criteria for ADHD
- Girls with ADHD 3.6 times more likely to have an eating disorder and 5.6 times more likely to have BN (related to impulsivity) (Reinblatt 2015)
- ADHD population more at risk of binge eating/purging behaviours rather than restricting (Reinblatt 2015)
- Given there is some evidence that impulsivity is implicated in conditions such as BED and BN, there is evidence that treatments for ADHD may help in eating disorder treatment

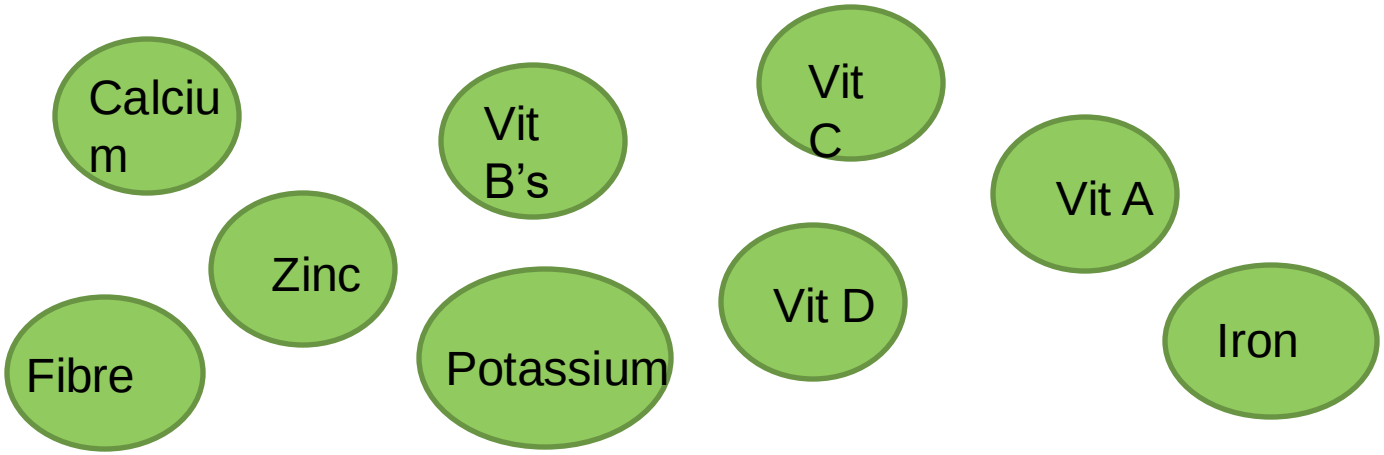
Treatment Considerations

- Currently no treatment guidelines for supporting autistic people with eating disorders
- Emerging evidence that Cognitive Remediation Therapy (CRT) and Cognitive Remediation and Emotional Skill training (CREST) are associated with improved
  - cognitive flexibility
  - motivation for change and
  - decreased alexithymia in AN with high ASD traits
- Therapies for ARFID are emerging with modifications to treatment for neurodiverse people with eating disorders
  - FBT – ARFID (Lock 2019)
  - CBT-AR (Thomas 2020)



Treatment Considerations in neurodivergent individuals with ARFID

- Nutritional Assessment is important due to potential for longstanding dietary limitations: high risk for nutritional deficiencies (vitamin B's, C, A & D and minerals like iron, calcium & zinc) and imbalances (fibre).



Commence nutritional rehabilitation with increased volumes of PREFERRED FOODS whilst treating deficiencies with vitamin supplements.

Redefining treatment /Treatment Modalities for eating disorders:

- Due to the complex nature of EDs an MDT including medical, mental health professionals and dietician for example is important.
- Treatment should also include family, carer, others supports and lived experience/peer workers in the treatment. They represent the voice of consumers and contribute to the recovery of the person with ED.
- Training can be provided to families and carers to prepare them to actively participate and support their loved one in treatment.
- Lived Experience and peer workers are also now represented in recruitment of staff in specialists ED services in service planning and development.
- More treatment modalities are now available and achieve similar results for example FBT, FBT-AR, CBT-Ten (online version), CBT-e , CBT-AR etc.
- Adjunct treatment therapies can also be added to the main ED therapies for example MFT, TBT-S, EFST-Youth and EFST-Parents and carers etc.

Timing of treatment

- Ealy intervention in ED, can help in onset ED by prioritising treatment following a diagnosis
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- More treatment modalities are now available and achieve similar results for example FBT, FBT-AR, CBT-Ten (online version), CBT-e , CBT-AR etc.
- Single Session Interventions which includes psychoeducation provided to the young person and their family/carer is essential in preparation for evidence-based treatment for Eds
- CBT-e and FBT are commonly used to treat adolescents with longstanding eating disorders who could benefit from recovery-based treatment that involves weight restoration.

Nutritional Rehabilitation using RAVES

Renourishment show involve RAVES.

Eating:

- REGULAR
- ADEQUATE
- VARIETY
- EATING SOCIALLY
- SPONTANEOUSLY

Rethinking weight goals in treatment for EDs

- When calculating and proposing weight ranges in weight restoration it is recommended that appropriate attention is paid towards each client/patient's specific context and background, rather than prescribing a "normal" BMI.
- Recent developments in treatment recommend considering the following:
  - Premorbid weight (if known)
  - Childhood body type (by requesting growth history (weight and height) from family and GP and Paediatricians
  - Biological family body type if available (discuss with parents)
  - Young persons weight history (highest and lowest weight) to guide developing the weight chart

Co-morbidities of Eating Disorders

- Co-morbidities are common for all ED's. Can affect treatment response and recovery
- In children/adolescents the common co-morbidities are:
  I. OCD, depression, anxiety, and ASD
  II. Substance abuse problems (up to 50% of people with an ED abuse illicit drugs and alcohol)

Medication use in Eating Disorders

- Medications are most useful when co-morbid disorders
- Unless there is a strong pre-eating disorder history of co-morbid disorder, it is often better to wait until the patient is re-fed to assess medication intervention
- Medications can r be used to manage acute exacerbations of anxiety, poor sleep and extreme aggression while re-feeding is occurring
- EDs may exacerbate anxiety symptoms, specifically the effects of starvation can contribute to depressive symptoms or depressive disorder. Mood therefore can improve with weight restoration only.
- Co-morbid disorders, may predict a longer course of illness or contribute to the development and intensity of ED symptoms

Main types of medications used in eating disorders:

- SSRI's - Used mainly to treat co-morbid anxiety/OCD/Depression
  - Fluoxetine has been shown to reduce binges by 50% in BN
- Anti-psychotics – Mainly used for acute exacerbations of anxiety, poor sleep, extreme aggression or augment SSRI's
  - Olanzapine and Quetiapine frequently used – remember to monitor for ECG changes and pathology investigations during metabolic monitoring
- Benzodiazepines – Not commonly used in community settings but in hospital setting can be used for extreme anxiety states
  - Diazepam most commonly used in hospital settings but need to keep dose low and duration of treatment short as possible

Take Home Messages

- Consider an eating disorder early in assessment
- Act quickly for referral/ management
- Help is available. Don’t have to manage alone
- Food is medicine
- Diet warning- everything in moderation
- No stigma, no shame, everything to gain by recognising and overcoming it early

Contact us

Eating Disorders Program – Greenslopes
Community Treatment Team
34 Curd Street, Greenslopes, QLD 4032
t 07 3397 9077 e CHQ-CYMHS-EatingDisorders@health.qld.gov.au

Eating Disorders Program – Chermside
Intensive Community Treatment Team (including Day Program)
Level 2, Chermside Galleria
831 Gympie Road, Chermside, QLD 4032
t 07 3084 2100
e CHQ-CYMHS-EatingDisordersDayProgram@health.qld.gov.au

CYMHS Acute Response Team
Crisis support and information (24 hours/7 days)
t 07 3068 2555

Question Time