BETTER OUTCOMES. TOGETHER.

KINARK

CHILDREN AND YOUTH

Understanding and Addressing Eating Disorders in Adolescents: A Guide to Basics and Treatments

Sarah King Audley M.A., RP
Tziporah (Tzippy) Bernstein, BASc, CDE, RD

Agenda

- Welcome and introduction
- Some facts about eating disorders
- Recognizing signs and symptoms in adolescents
- Case studies: from diagnosis to treatment
  - Anorexia Nervosa: Restrictive; ARFID
  - Anorexia Nervosa: Binge-Purge; BED
- Community resources to support youth with recovery
- Q&A

Facts about Eating Disorders

- Nearly 1 million individuals are diagnosed with an eating disorder at any given time
  - Early detection and intervention are important
- Eating disorders often co-occur with other mental health conditions, such as depression, anxiety disorders, obsessive compulsive disorder and substance abuse
- Individuals with eating disorders are at a higher risk for self-harm and suicide
- Eating disorders have the highest mortality rate among all mental health diagnoses
- Eating disorders can be associated with significant compromise in every organ system of the body, including the cardiovascular, gastrointestinal, endocrine, dermatological, hematological, skeletal, and central nervous system

Recognizing Signs and Symptoms in Adolescents

- Drastic weight changes
- Excessive concern with body image
- Diet restrictions
- Excessive exercise
- Avoidance of meals
- Social withdrawal
- Mood swings
- Constant self-critique
- Increased social media use
- Impaired concentration
- Memory problems
- Reduced problem-solving skills
- Slower reaction times
- Decreased attention span
- Obsessive thoughts
- Decreased energy levels

Case Studies

Haley's Story

A 16 year-old female, Haley, has been restricting food for 2-3 years. Most days she doesn't eat breakfast, or lunch, and then eats dinner with her family. Recently she has been making excuses to not eat a full dinner or to avoid eating with her family. She doesn't want her family to know. She has difficulty eating in front of her peers/friends, has rules about eating which include not eating meals that are above a certain amount of calories, she has foods that she won't eat (French fries, pizza, pasta), she finds herself comparing herself to friends/peers her age, she scrutinizes herself in the mirror, she weighs herself every day and exercises in her room at night by doing HIIT videos to burn calories.

Recently she has been feeling lightheaded/faint at school and went to see her family doctor. She shares with her parents that she has been having difficulty concentrating in class. Her doctor notices that her weight has significantly decreased and is now at 85% of what it was a year ago and, after speaking with Haley, the GP diagnoses her with **Anorexia Nervosa-Restrictive Type.**

Anorexia Nervosa: Restrictive

Criteria for diagnosis:

- Restriction of energy intake
- Intense fear of weight gain
- Distorted body image
- No recurrent episodes of binge-eating or purging behaviours

SYMPTOMS

Eating Patterns

- **Restrictive eating**
- **Avoidance of certain foods**

Physical Symptoms

- **Weight loss**
- **Amenorrhea**
- **Fatigue and weakness**
- **Cold intolerance**
- Skin changes
- **Dizziness/fainting**
- Low blood pressure
- Slowed heart rate
- GI distress
- Brittle hair and nails

Emotional and Psychological Symptoms

- **Distorted body image**
- Low self-esteem
- Depression and **anxiety**
- Social withdrawal
- Difficulty concentrating
- **Difficulty sleeping**
- **Extreme fear of gaining weight**

Behavioural Symptoms

- **Rules/rituals around eating**
- Preoccupation with food
- **Compulsive exercise**
- **Preoccupation with body shape, weight, and size**

Treatment Considerations

- Biological, psychological, and social/environmental factors
- Comprehensive assessment (medical, psychological, social functioning)
- Level of care required and intensity of treatment
- Medical monitoring
- Multidisciplinary team
- Concurrent mental health disorders
- Motivation of young person and egosyntonic nature of ED
- Support for caregivers/parents

Family-Based Treatment (FBT)

Key principles:

- Agnostic approach (NO blame)
- Externalized the eating disorder
- Non-authoritarian approach
- Caregiver responsibility for re-nourishment/weight restoration
- Three phases

Other Evidence-Based Treatments

- Enhanced Cognitive Behavioural Therapy (CBT-E)
- Dialectical Behavioural Therapy (DBT)
- Emotion-Focused Family Therapy (EFFT) for caregivers/parents

Treatment Goals

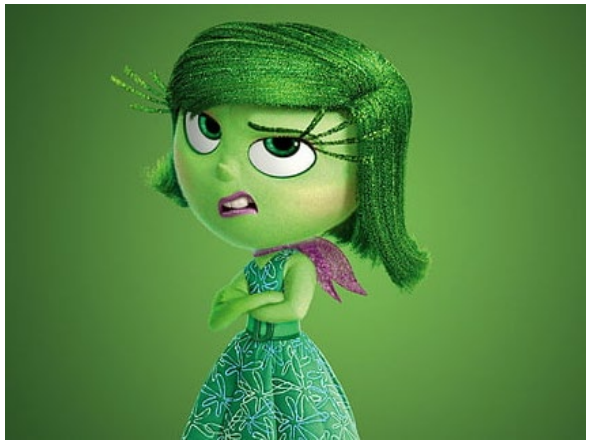
- Maintain wellness weight
- Increase overall health and wellness
- Decrease eating disorder related thoughts, beliefs, and behaviours
- Improve psychosocial functioning and support development of the individual's identity without the eating disorder, develop new ways of adapting, and coping with stress
- Promote independence, appropriate with developmental age, with planning, preparation, plating meals, and snacks

Avoidant Restrictive Food Intake Disorder (ARFID)

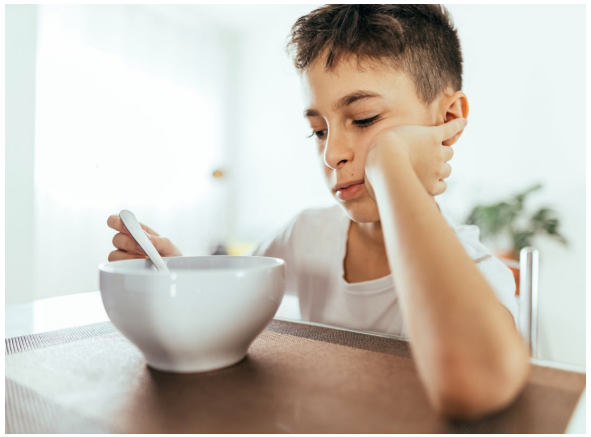
What is Avoidant Restrictive Food Intake Disorder (ARFID)?

An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

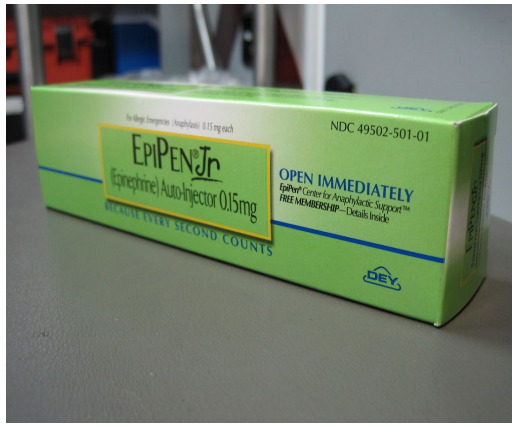
- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children)
- Significant nutritional deficiency
- Dependence on enteral feeding or oral nutritional supplements
- Marked interference with psychosocial functioning
- Not explained by food insecurity or a culturally sanctioned practice
- Not related to experience of body weight, shape, or size
- Occurs exclusively without anorexia nervosa or bulimia nervosa
- Not attributable to concurrent medical or mental health condition



Sensory aversions



Lack of interest



Fear of aversive consequences

Causes and Risk Factors

- Multifactorial
- Genetic component
- Environment including history of traumatic experience (e.g. choking or allergic reaction)
- Concurrent mental health disorders (anxiety, OCD, ADHD)
- Commonly found in those living with Autism Spectrum Disorder (ASD)

Signs and Symptoms

- Consistent low weight for height and age
- Weight loss
- Change in mood (anxiety/depression)
- Fatigue/low energy
- Feeling cold
- Difficulty concentrating
- Hair loss
- Gastrointestinal discomfort
- Lack of appetite
- Medical instability requiring hospitalization

Treatment Options

ARFID represents 5-23% of children presenting in eating disorder treatment centers and 2% of those admitted to Gastroenterology clinic

- Consideration of required level of care
- Cognitive Behavioural Therapy (CBT)-ARFID
- Family-Based Therapy (FBT) for ARFID
- Dietitian support and medical monitoring
- Family/caregiver support

Treatment Objectives for ARFID

- Develop routine eating patterns
- Address barriers/challenges to nourishment (fears, anxiety, sensitivities, discomfort) collaboratively with the child/youth
- Address nutritional deficiencies by dietitian support and increasing the variety of foods
- Achieve wellness weight and maintain appropriate weight by implementing these changes/strategies

Lily's Story

A 17-year-old female, Victoria, has been struggling with disordered eating patterns over the last year. Victoria began to restrict her food due to body shaming comments heard at school. She started skipping breakfast and throwing out her lunch at school. She always ate dinner with her parents and younger brother so parents would not be alerted to her new eating patterns. Once the rest of her family would fall asleep, she would sneak downstairs and participate in binge-eating episodes most nights, followed by self-induced vomiting (purging).

She played on her school's volleyball team and participated in dance outside of school. Since these **binge-purge episodes**, Victoria has been feeling tired all day, has had downward trends in school grades, and decreased energy for volleyball and dance. Three months ago, her mother overheard her vomiting in the bathroom after dinner one night. Seeing how parents had prior concerns about her weight loss and changes in behaviour, they took her to their family doctor. After learning Victoria had not been getting regular periods, purging daily, and counting calories, her doctor diagnosed her with **Anorexia Nervosa: Binge-Purge subtype.**

Anorexia Nervosa: Binge-Purge

Criteria for diagnosis:

- Restriction of energy intake
- Intense fear of weight gain
- Distorted body image
- Binge-eating and purging

SYMPTOMS

Eating Patterns

- **Restrictive eating**
- **Binge eating**
- **Purging behaviours**

Physical Symptoms

- **Weight loss**
- **Amenorrhea**
- **Fatigue**
- Cold intolerance
- Skin changes
- Dizziness
- Low blood pressure
- Slowed heart rate
- **GI distress**
- Brittle hair and nails

Emotional and Psychological Symptoms

- **Distorted body image**
- Low self-esteem
- Depression and anxiety
- **Social withdrawal**
- Difficulty concentrating
- Difficulty sleeping

Behavioural Symptoms

- **Secrecy around eating**
- Preoccupation with food
- Compulsive exercise

Treatment Type and Length

Medical Monitoring

- Regular check-ups with primary care provider (labs, blood pressure, etc.)
- Weekly monitoring of weights
  - **Blind:** Client does not know the value
  - **Non-blind:** Client does know the value

Nutrition Psychoeducation and Counselling with a Dietitian

- Gradual reintroduction of food in a structured manner to normalize eating patterns and minimize bingeing tendencies
- Mechanical eating with progression to re-learning, listening, and honouring hunger and fullness cues
- Understanding the fundamentals of nutrition to support decision making that will nourish mind, body, and soul

Treatment Type and Length (cont'd)

Coping Strategies

- Development of skills to manage stress and anxiety
- Encouragement of hobbies that promote self-esteem and body positivity

Psychotherapy

- Family-Based Therapy (FBT) Involves the family as a key component in the recovery process and focuses on restoring individual's **wellness weight** and relationship with food
- Cognitive Behavioural Therapy (CBT): A focus on changing negative thought patterns related to body image and self-worth
- Emotion-Focused Family Therapy (EFFT): Involvement of family members to improve communication and understanding
- Group therapy: Participation in support groups for adolescents with EDs to foster connection and shared experiences

Lily's Expected Progress and Outcomes

Short-term (1-3 months): Stabilized weight, establish regular eating patterns, and initiate therapy

Long-term (6-12 months): Achieve "wellness weight", improve body image, and develop effective coping mechanisms

Length of treatment will vary considerably on an individual basis

Binge-Eating Disorder (BED)

What is Binge-Eating Disorder (BED)?

- **Definition:** BED is characterized by recurring episodes of eating large quantities of food, often quickly and to the point of discomfort.
- **Key Features:**
  - Eating more rapidly than normal
  - Eating until uncomfortably full
  - Eating large amounts when not physically hungry
  - Feelings of disgust, depression, or guilt after overeating

Diagnosis

Criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5):

- Recurrent episodes of binge eating
- Marked distress regarding binge eating
- Occurs at least once a week for three months
- No regular use of inappropriate compensatory behaviors (unlike bulimia)

Causes and Risk Factors

Biological Factors:

- Genetic predisposition
- Neurotransmitter imbalances (e.g., serotonin)

Psychological Factors:

- Low self-esteem, depression, or anxiety
- Emotional triggers (stress, trauma)

Environmental Factors:

- Diet culture, societal pressures, or trauma-related experiences

Signs and Symptoms

Physical Signs:

- Fluctuations in weight
- Hoarding food or eating in secret

Emotional Symptoms:

- Preoccupation with food and eating
- Distress around eating habits

Behavioral Changes:

- Withdrawal from social situations involving food

Treatment Options

Psychotherapy:

- **Cognitive Behavioral Therapy (CBT):** Focuses on changing negative thought patterns and behaviours
- **Interpersonal Therapy (IPT):** Addresses interpersonal issues and their relation to eating behaviours

Medication:

- Selective Serotonin Reuptake Inhibitors (SSRIs) may help reduce binge-eating episodes

Nutritional Counselling:

- Developing a balanced, structured eating plan

Coping Strategies

Mindfulness and Stress Management:

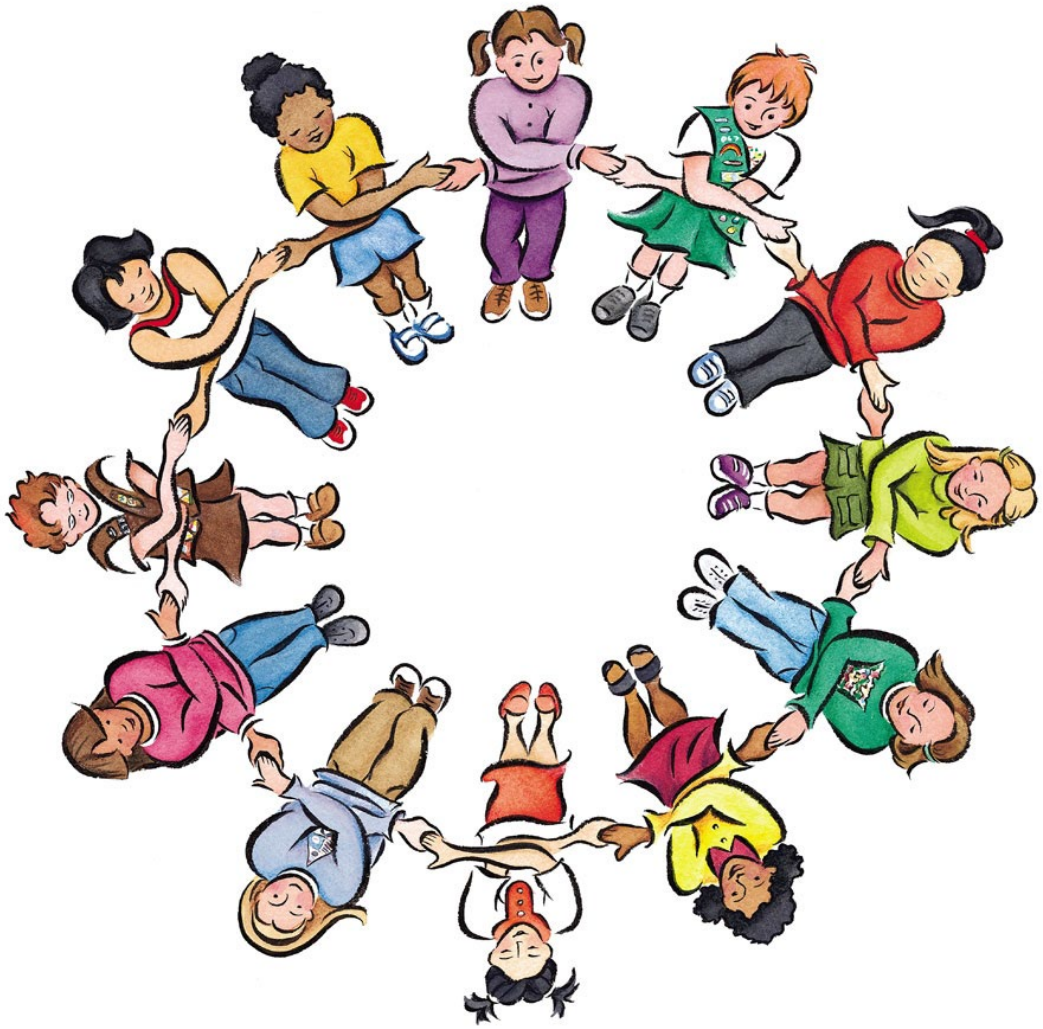
- Techniques like meditation and deep breathing to manage triggers

Support Groups:

- Connecting with others who understand the challenges

Healthy Lifestyle Changes:

- Incorporating regular physical activity and focusing on overall wellness



Treatment Options

Inpatient

- Hospital-based care for those with required intensive medical interventions and monitoring
  - Medical monitoring
  - Re-feeding; meal support
- Often short-term and for medical stabilization
- Multidisciplinary team

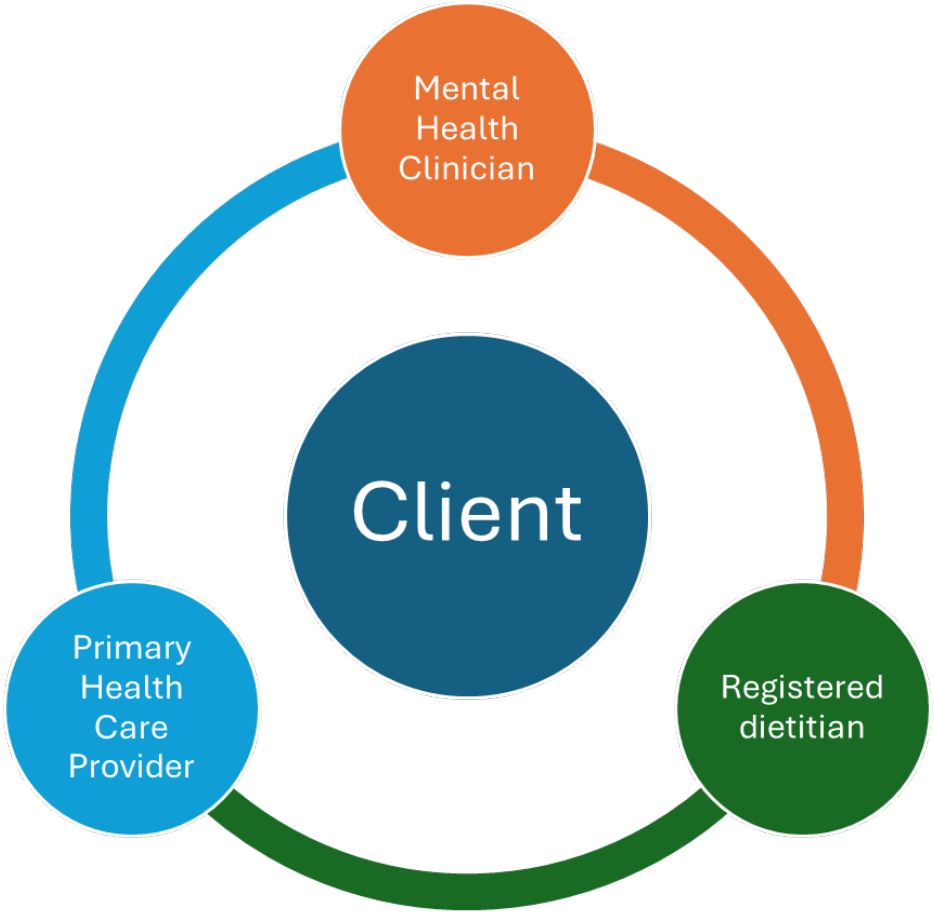
Day Treatment

- Medically stable
  - Not ready for re-integration to "normal" life
- Typically, 5 days/week, full-day program
  - School curriculum
  - All meals with supervision
- Multidisciplinary team

Outpatient Treatment

- Medically stable
- Can be treated by attending weekly therapy and other regular follow-ups with health care professionals
  - Registered Dietitian
  - Registered Nurse
- Opportunity for flexibility
- Real-life application

Multidisciplinary Team



- Individual therapy
- Family therapy
- Nutritional support from registered dietitian
- Regular Monitoring from Primary Health Care Provider

Community Programs and Supports

National Eating Disorder Information Centre (NEDIC)

https://www.nedic.ca

- Helpline available

Eating Disorders Ontario (EDO)

https://eatingdisordersontario.ca/wp-content/uploads/Eating-Disorders-Ontario-List-of-Treatment-Programs-August-2024.pdf

Key Takeaways

Eating disorders are **serious**, complex mental health disorders that affect emotional health, physical health and psychosocial wellbeing and is associated with **severe** mental health and physical risks.

Eating disorders do not discriminate. They can affect individuals of all ages, genders, ethnicities, socioeconomic backgrounds, and all body shapes, weights, and sizes.

Early interventions and family support is critical in a successful recovery.

Q&A

References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th ed.).* Arlington, VA: American Psychiatric Publishing.

Treasure, J., Stein, D., & Maguire, S. (2015). *Anorexia Nervosa: A Practical Guide to Diagnosis and Management.* Cambridge University Press.

Culbert, K. M., Racine, S. E., & Wildes, J. E. (2015). *Eating Disorders in Adolescents: A Review of the Evidence. Adolescent Health, Medicine and Therapeutics,* 6, 85–96. doi:10.2147/AHMT.S69730

Le Grange, D., & Lock, J. (2005). *The Role of the Family in the Treatment of Eating Disorders: A Review of the Literature. International Journal of Eating Disorders,* 37(2), 111-118. doi:10.1002/eat.20163

Hay, P. J., & Carriage, C. (2020). *Anorexia Nervosa and Related Disorders: A Review of Current Evidence for Clinical Practice. Australian & New Zealand Journal of Psychiatry,* 54(5), 425-436. doi:10.1177/000486742091434l

Murray, S. B., & Touyz, S. (2013). *The Role of Cognitive Behavioral Therapy in the Treatment of Eating Disorders: A Review of the Evidence. International Journal of Eating Disorders,* 46(5), 397-407. doi:10.1002/eat.22168

References

Kendall, T., et al. (2013). *Eating Disorders: Recognition and Treatment. NICE Clinical Guideline 9.* National Institute for Health and Care Excellence.

Eisler, I., et al. (2000). *Family Therapy for Anorexia Nervosa: The New Maudsley Approach. Journal of Family Therapy,* 22(3), 310-319. doi:10.1111/1467-6427.00160

National Eating Disorders Association (NEDA). (n.d.). *Binge Eating Disorder.* Retrieved from nationaleatingdisorders.org

Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). *Estimating the Prevalence of Eating Disorders in the National Comorbidity Survey Replication. Biological Psychiatry,* 61(3), 348-358. doi:10.1016/j.biopsych.2006.03.040

Grilo, C. M., & Mitchell, J. E. (2010). *Binge Eating Disorder: A Comprehensive Review. Journal of Clinical Psychiatry,* 71(8), e1–e7. doi:10.4088/JCP.08r04886

Wilfley, D. E., & Hemminger, N. J. (2018). *Psychological Treatments for Binge Eating Disorder. Current Psychiatry Reports,* 20(11), 96. doi:10.1007/s11920-018-0983-5

Stice, E., Marti, C. N., & Rohde, P. (2013). *Prevention of Eating Disorders: A Meta-Analytic Review. Annual Review of Clinical Psychology,* 9, 337-363. doi:10.1146/annurev-clinpsy-050212-185010

References

Parker, J. D., et al. (2020). *Understanding Binge Eating Disorder: A Guide for Healthcare Professionals. American Journal of Lifestyle Medicine,* 14(5), 524-528. doi:10.1177/1559827619843348

Drewnowski, A., & Almiron-Roig, E. (2010). *Human perceptions and preferences for fat-rich foods. Physiology & Behavior,* 103(5), 639-647. doi:10.1016/j.physbeh.2011.01.007

Hornberger et al. (2021) Identification and Management of Eating Disorders in Children and Adolescents, American Academy of Pediatrics, Clinical Report.

Couturier et al. (2020) Canadian practice guidelines for the treatment of children and adolescents with eating disorders, Journal of Eating Disorders, 8:4.

Reilly et al. (2020) Dialectical behavioral therapy for the treatment of adolescent eating disorders: a review of existing work and proposed future directions, Eating Disorders, 28:2, 122-141, DOI: 10.1080/10640266.2020.1743098

Thomas et al. (2020) Cognitive-behavioral therapy for avoidant/restrictive food intake disorder: Feasibility, acceptability, and proof-of-concept for children and adolescents, International Journal of Eating Disorders, DOI: 10.1002/eat.23355

National Eating Disorder Information Centre. (n.d.). Retrieved from https://www.nedic.ca