CYMHS Eating Disorder Program

Eating Disorders in Children and Adolescents

Presenter:
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(Credentialed Mental Health Nurse)
Classifying eating disorders:

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

- Increase in adolescents 15-19 year old
- In Australia it’s estimated that 913,986 approximately 4% of the population
- Prevalence of AN 3%, BN 12%, BED 47% and 38% other eating disorders
- 15% of women will experience an ED at some point and 20% have an undiagnosed
- Female make up 64% of EDs
- EDs are the 3rd most common chronic illness in young women
- Between 1995 and 2005 prevalence doubled in both male and female aged 15 and older
- The prevalence of ED is increasing amongst boys and men
- Prognosis is poor and longstanding illness
- At least 50% will be readmitted many times despite good management
- In comparison to the general population, mortality rates are twice higher for people with EDs and rises to 5.86 times higher for people with AN
- Death commonly result from medical complications or suicide as main cause of death
Behaviours you may come across

• Bargaining
• Minimising
• Guilt/emotional tactics
• Difficulty making decisions
• Behaviours
  • 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)
Wide range of physiological changes including:

- Amenorrhoea
- Changes in vital signs
- Bloods
- Bones/muscle
- ECG changes
- Chronic fatigue
- Cardiovascular
- Neurological symptoms

Psychological changes:

- Depression
- Anxiety
- Personality disorders
- Rigidity/change in personality
- Obsessiveness
- Preoccupation with food
- Body image disturbance
- Social withdrawal

Other Associated Factors/Comorbid Disorders
Risk Factors

- Dieting is the greatest risk factor for the development of eating disorders
- Body image/body dissatisfaction
- Genetic/family history
- Mood dysregulation increases risk of development and maintains EDs. It also reduces the ability to manage emotion/impulse regulation
- Environmental/Socio-cultural factors
- Jobs/interests: ballet/sports
- Glorification of being thin/demonization of being fat
- Increased media influence/access to media
- Personality traits such e.g. anxious, perfectionistic and obsessional trait
- Other mental health disorders for example depression/anxiety disorders
Minnesota Starvation study

By Ancel Key's


- 1944/1945 - WWII
- 32 men – conscientious objectors drafted into the US army
- Three phases of the experiment
- 3 months of normal eating (3600cal)
- 6 months where rations were cut by 50% (1800cal)
- 3 months of full rations (3600cal)
- 12/52 control phase – 3200kcal
- 12/52 Restricted refeeding
- 8/52 Unrestricted refeeding
- 6 months of semi ration/starvation phase the men lost (25% loss of body weight) around 1560 Kcal/day
- Their hearts (muscle), also reduced by 25%, and slowed down. Their BMR slowed down so their body could save energy
Eating Disorders Medical Issues/complications

**Anorexia affects your whole body**

**Brain and Nerves**
- can’t think right, fear of gaining weight, sad, moody, irritable
- bad memory, fainting, changes in brain chemistry

**Hair**
- hair thins and gets brittle

**Heart**
- low blood pressure, slow heart rate, fluttering of the heart (palpitations), heart failure

**Blood**
- anemia and other blood problems

**Muscles and Joints**
- weak muscles, swollen joints, fractures, osteoporosis

**Kidneys**
- kidney stones, kidney failure

**Body Fluids**
- low potassium, magnesium, and sodium

**Intestines**
- constipation, bloating

**Hormones**
- periods stop, bone loss, problems growing, trouble getting pregnant. If pregnant, higher risk for miscarriage, having a C-section, baby with low birthweight, and postpartum depression.

**Skin**
- bruise easily, dry skin, growth of fine hair all over body, get cold easily, yellow skin, nails get brittle

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**How bulimia affects your body**

**Blood**
- anemia

**Heart**
- irregular heart beat, heart muscle weakened, heart failure, low pulse and blood pressure

**Body Fluids**
- dehydration, low potassium, magnesium, and sodium

**Intestines**
- constipation, irregular bowel movements (BM), bloating, diarrhea, abdominal cramping

**Hormones**
- irregular or absent period

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**Brain**
- depression, fear of gaining weight, anxiety, dizziness, shame, low self-esteem

**Cheeks**
- swelling, soreness

**Mouth**
- cavities, tooth enamel erosion, gum disease, teeth sensitive to hot and cold foods

**Throat & Esophagus**
- sore, irritated, can tear and rupture, blood in vomit

**Muscles**
- fatigue

**Stomach**
- ulcers, pain, can rupture, delayed emptying

**Skin**
- abrasion of knuckles, dry skin

Dash line indicates that organ is behind other main organs.
Current Practice Guidelines
Interpretation and use

- Statewide Guideline- Access Pathways.. (old guidelines)
- Nutritional management for children and adolescents with eating disorders
- The National Agenda for Eating Disorders 2017-2022
<table>
<thead>
<tr>
<th>Anorexia Nervosa</th>
<th>Bulimia Nervosa</th>
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<tbody>
<tr>
<td>• Rapid wt loss (&gt;1kg/week avg. over 6 weeks)</td>
<td>• Syncope</td>
</tr>
<tr>
<td>• Weight loss of &gt;15% of pre-morbid weight in last 3-6 months</td>
<td>• Serum potassium &lt;3.2mmol/L</td>
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<td>• Refusal of oral intake</td>
<td>• Serum Chloride &lt;88mmol/L</td>
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<tr>
<td>• Resting Pulse &lt;50 bpm</td>
<td>• Oesophageal tears</td>
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<tr>
<td>• Systolic pressure &lt;80mmHg</td>
<td>• Cardiac arrhythmias including prolonged QTc interval &gt;450msec</td>
</tr>
<tr>
<td>• Orthostatic changes in pulse (&gt;20bpm) or BP (&gt;20mmHg)</td>
<td>• Hypothermia (Temp &lt;35.5°C)</td>
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<tr>
<td>• Dehydration/refusing fluid intake</td>
<td>• Intractable vomiting</td>
</tr>
<tr>
<td>• Ketosis</td>
<td>• Suicidal ideation</td>
</tr>
<tr>
<td>• <strong>Hypothermia (Temp &lt;35.5°C)</strong></td>
<td>• Hematemesis (blood in vomit)</td>
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<td>• Cold/blue extremities</td>
<td>• Severe family stress and strain and/or behaviours relating to eating disorder impacting on child/adolescent and family functioning</td>
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<tr>
<td>• Presence of any Arrhythmia on ECG</td>
<td>• Suicidality/self-harm that is unable to be managed in Outpatient setting</td>
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<tr>
<td>• Prolonged QTc interval &gt;450msec</td>
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<tr>
<td>• Any electrolyte abnormalities esp. Magnesium (Mg²⁺), Phosphate (PO₄³⁻) and Potassium (K⁺)</td>
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<tr>
<td>• Hypoglycaemia</td>
<td></td>
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CYMHS Eating Disorder Program

- Program Manager
- Medical Director Psychiatrist
- CNC/Team Leader
- *Allied Health
- Clinical Nurse
- Nurse Practitioner
- Dietitian
- Paed
- Psych Registrar
- Virtual Teams

Children’s Health Queensland
Clinical Team

- The Eating Disorders Team is located at Greenslopes south Brisbane, is part of the Children’s Health Queensland Child and Youth Mental Health Service.
- We provide specialist treatment to families of children or adolescents with eating disorders living in the greater Brisbane area.
- All team members are CYMHS clinicians and have specific training in treating Eating Disorders.
- Each family is assigned to at least one case manager(s) who will be their primary treating therapist and who will coordinate all aspects of treatment in the team.
- Other team members are involved with families depending on clinical need.
Parts of the Continuum of Care for Eating Disorders that may be accessed in CHQ

- CYMHS EDT
- Emergency Department (QCH or RBH)
- CYMHS IPU Child or Adolescent
- CYMHS Consultation Liaison Team
- CYMHS Acute Response Team
- QCH Emergency Department
The Role of CYMHS EDT in the Continuum of Care for Children and Adolescents with Eating Disorders

- Collaboration / Care Coordination with patient/family and relevant stakeholders GP, Emergency Department/Paediatric team and facilitate transfer of patient to the hospital for medical admission
- Liaise with hospital based CYMH Teams (Acute Response Team and Consultation Liaison Team and Inpatient Units) to alert patient transfer
- Liaise with hospital teams including medical ward for discharge planning and organise further assessment appointment with the family to confirm diagnosis and discuss community treatment plan before discharge
- Treatment suitability include Family Based Therapy for Anorexia Nervosa, Cognitive Behavioural Therapy Enhanced, Supportive Therapy or Case Management
- Treatment intervention recommended, patient and family agree and consent to start treatment
- FBT Therapist (s) allocated for the adolescent and their family and they commence treatment.
Outpatient Treatment - Current Clinical Services

Comprehensive assessment and diagnosis
- Psychiatric assessment
- Physical assessment and investigation
- Nursing and medical monitoring

Evidence-based Psychological interventions
- Family Based Treatment – Anorexia Nervosa (most researched intervention))
- Cognitive Behavioural Therapy –Enhanced (Bulimia Nervosa and Binge eating disorders)
- Case Management with family therapy, individual, risk management
- Family Based Therapy for Anorexia Nervosa telemedicine (currently under research with feasibility study)
- Pharmacological management – Use of Selective Serotonin Re-uptake Inhibitors (SSRIs)
State-wide Services Summary

- Second Opinion Assessment
- Complex Case Review
- Consultation
- FBT-AN Telehealth (research pilot)
- FBT-AN supervision
- FBT-AN training in collaboration with the Institute planned for 2018/2019
- CBT-e mentoring/supervision group (under development)
Family Based Therapy for Anorexia Nervosa

Principles of Maudsley FBT

- FBT is considered first line treatment for all eating disorders in CHQ HHS
- Agnostic view of AN’s aetiology
- Target of treatment is the ‘Anorexia’ and weight gain is prioritized over other issues
- Families are seen as the best resource to fight AN
- “Anorexia” is externalized from the patient (illness versus adolescent behavior)
- Medical safety precedes adolescent issues
- Hospitalization is a temporary solution
Phases of treatment

- Phase One (Sessions 1-12)
  Parental control of weight restoration

- Phase Two (Sessions 11–16)
  Returning developmentally appropriate choices over eating back to the child or adolescent

- Phase Three (Sessions 17-20)
  Adolescent Development, family restoration, relapse prevention and treatment termination
Dietary choices, food allergies and intolerances.

- **Vegan diet usually not suitable** during treatment, vegetarian **considered** if dietary choice precedes diagnosis/restrictive behaviours.

- **Diagnosis of allergies required** – with the use of adequate alternatives to foods that need to be removed. Intolerances must be carefully considered before food items are omitted.

- **Gastrointestinal problems:** one of the most common consequences of an eating disorder- bloating, constipation, diarrhoea, flatulence, abdominal pain, fullness after eating small amounts – GI changes are believed to be caused by starvation, malnutrition and underuse of the GI tract.
How is re-feeding different to normal eating?

- **Food is medicine.**
- Medical monitoring is *vital*.
- Energy requirements change throughout treatment.
- Regular eating: 6 times per day; 3 hours apart; everyday.
- Eating **more than** “normal” intake and **more than** other family members.
- No low fat or diet foods.
- Kids need parents to provide the control over the what, where and when of eating.
- Parental meal planning can ensure consistency and variety.
- Child should not be involved in cooking, shopping or meal planning.
Overview of Accessible Eating Disorder Services / Resources

- CYMHS EDT
- Queensland Eating Disorders Service
- Eating Disorders Queensland
- Centre Clinical Interventions website
- Local private practitioners
- GPs with interest in Eating Disorders
Contacts:

Persons:

• Penny Knight - Team Leader/CNC
• Tania Withington – Program Manager
• Dr Sam Catania – Medical Director
• Edith Nkweny - Nurse Practitioner

Address and Phone Numbers:

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Reference List


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