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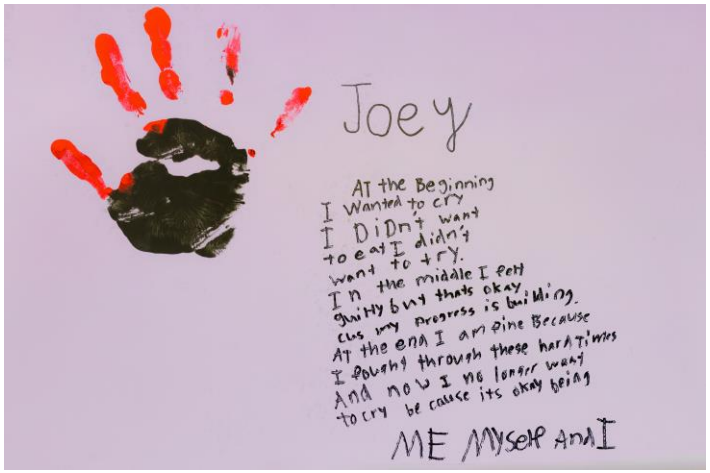
Caring for Teens with Eating Disorders: What your patients want you to know

PSV Adolescent Partial Hospital
Eating Disorder Program
November 9. 2022

Reflection: The meaning of recovery to three teens



Objectives:

- Brief review of the physical and emotional consequences of eating disorders
- Strategies for interacting sensitively with patients and families
- Diversity issues impacting the PSV Partial Hospital and IOP patients
- Q and A

- The planning committee and faculty have no relevant financial relationships with commercial interests to disclose.

Overview

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder (BED)
- ARFID
- OSFED

- Orthorexia- no diagnostic criteria

ARFID

- Avoidance or restriction of food intake leading to one or more of the following:
  - wt loss or slowed growth
  - Nutritional deficiency
  - Interference with psychosocial functioning
  - Need for supplemental nutrition

  Subtyping: disinterest in food, sensory or textural problems, phobic experiences

  Exposure and adjunctive therapies (OT, PT, speech)No evidence-based treatment yet.

Eating Disorder or Disordered Eating?

- Disordered eating is estimated to be quite common in the population but is hard to measure. Examples include:
- Rigid food or exercise patterns
- Guilt shame and preoccupation when those routines are not upheld
- Emotionally driven eating
- Constant dieting as a lifestyle
- Disordered eating may or may not give rise to diagnosable eating disorders

Disordered Eating or an Eating Disorder?

- History
- Function in an individual's life
- Level of obsessiveness
- Ability to sustain abstinence

- Often challenging to parse out and requires EDO evaluation by expert clinicians

Transdiagnostic Features of Eating Disorders

- Abnormal relationship to food
- Includes some degree of psychological distress
- Involve medical abnormalities
- Experience functional impairment in areas of life
- Typically have comorbid disorders
- May migrate from one diagnosis or subtype to another over time
- Typically involve families/partners in diagnosis and treatment
- Multidimensional in origin (genetic, environmental & developmental forces)
- Are true illnesses
- Share common modes of treatment

Transdiagnostic Features continued

- May present variably- in different forms
- Are generally ego-dystonic
- Treatment involves acknowledging existential issues involving identity and self-worth ***
- Are true illnesses and not simply bad choices or moral flaws

- Mehler & Andersen 2022

What it takes to understand the disorders

Complex causality= complex solutions

- Genetic vulnerability to development of eating disorders ranges from 40-70%
- Epigenetic approaches which examine the interaction between genetic vulnerability and environmental factors are thought to play a large role.
- Pts begin to understand the complexity of their disorder retrospectively, as they obtain distance from symptoms and begin recovery
- Simplistic/reductionistic suggestions are unwelcome, hurtful and can disrupt trust building processes.

Physical Concerns: The patient experience

- Patients are often so cut off from their experience of their body that they are unable to acknowledge how ill they are becoming.
- They often comment upon improved energy levels and cognition *after* an interval of refeeding/rehydration.
- Conversely, in a subset of patients, the health concerns serve as a “wake up” call.
- AN had highest mortality rate but is now competing with substance use disorders.

Medical Evaluation is a treatment priority

- Urgent issues include
  - Unstable vital signs
  - Severe starvation as evidenced by low BMI
  - Hypokalemia
  - Cardiac arrythmia
  - Prolonged QT interval
  - Altered consciousness

Medical Evaluation

- Longer term issues include:
  - Osteoporosis/osteopenia
  - Starvation related brain changes
  - Weight redistribution
  - Height restriction
  - GI tract slowing

Medical symptoms that improve with treatment

- Orthostasis
- Hypothermia
- Bradycardia
- Amenorrhea
- Starvation related hypothyroidism

Concerns about growth as the illness occurs in younger patients

- Energy insufficiency related to dietary restriction may result in:
- cessation of growth and loss or shortening of critical growth spurts
- Interrupted puberty
- Diminished development of bone density which may not be reversible.
- Information gathering proceeds differently with preteens due to less self-awareness or difficulty describing emotions.
- Importance not to suggest symptoms that may not have occurred to younger kids.

Emotional Suffering

- High co-morbidity with anxiety, depression, OCD, trauma and substance use.
- Shame, secrecy and ambivalence dominate the inner experience of the individual impacted.
- The temperament of the individual can complicate open discussion of symptoms (sub assertiveness, people-pleasing, minimization, denial, invincibility or outright “protection” of the eating disorder.
- Lack of being emotionally present in their own life.
- Mental occupancy of the eating disorder
- Sneakiness of the eating disorder

The suffering extends beyond the individual:

- Families need help and support. Expressed anger and criticism toward the person suffering typically leads to interpersonal retreat and increased symptoms.
- Parents often feel guilty about the emergence of symptoms in their child- encourage adoption of agnostic view
- Parents/supports may not understand the complex nature of the illness.
- Patients and families struggle with their own and others judgment as well as simplistic efforts to help (scare tactics or “just eat”).

Conceptualizing the eating disorder as separate from the individual….

- Individuals grow in their ability to separate their eating disordered thoughts and behaviors from their healthy voice.
- This conceptualization offers a way of talking about symptoms in a less judgmental way while also validating the internal battle that the individual experiences.
- Whenever possible reinforce the existence of the healthy voice/perspective *even* if it is not evident.
- Express willingness/interest in helping the patient manage the illness and move toward recovery.

What about eating?

Patients often express a desire to become “healthier” rather than move toward recovery by letting go, grieving and demonstrating multiple acts of courage required by recovery.

- Tremendous support required to normalize meals (treatment, family meal structure, skype meals/snacks)
- Emerging evidence that more aggressive refeeding outweighs the risk of continued low body weight
- Simultaneously recovery is about eating but requires more than eating.

Longer term nature of treatment

- “Attaining a healthy body weight and resolving abnormal behaviors and cognitions is the beginning of comprehensive treatment, not the end. The goal is to instill flourishing- language for encouraging, to the maximum degree possible, a humanistic life that is creative, flexible and resilient.”

- Mehler & Andersen, 2022.

What do we know about recovery?

- Myth- Eating disorders are always chronic
- " The large majority of cases are acute, and patients improve rapidly with skilled care, remitting in up to 75% of cases for younger patients. About 50% or more adults may remit without detectable eating disorder symptomatology"

- Mehler & Andersen 2022.

Profiling patients with eating disorders

- Myth- Eating Disorders occur only in spoiled , white, suburban, upper class teen girls.
- “Eating Disorders are equal-opportunity illnesses, occurring at all ages (7-77), in both genders, in all ethnic and racial groups, in sexual minorities, in all locations.”
- Mehler & Andersen, 2022

What patients find most annoying

- Simplistic formulations or advice
- Expecting that patients can explain their behaviors
- Attributions related to attention seeking
- Vanity
- Control
- Will power
- Coercion/scare tactics
- Overidentification of those who do not have EDO
- Poorly coordinated care among team members
- Insensitivity about the challenges inherent in recovery
- Glamorizing their body size/shape

Diversity Issues encountered in PSV Adolescent EDO Partial Program

- Increasing SES diversity and associated practical and cultural considerations.
- Increased gender fluidity and gender exploration
- Increasing numbers of males involved in the program
- Increased HBW Anorexia Nervosa pts seeking treatment

Takeaways

- Patients are always teaching us what they need but we need to listen carefully and ask nuanced questions
- Feeling understood is powerful and relieving
- Motivation for recovery is fluid
- Teens who are "stuck" in symptoms are helped by the creation of a strong safety net until maturation helps them move more fully into recovery.
- Treatment team and support system members can hold hope for patients until they can embrace it for themselves.
- It takes a team- partner with dietitians and therapists
- Partnerships matter
- Rule in versus ruling out EDO-

To access PSV partial hospital program:

- Epic E consult process for both adults and adolescents
- Weekly free information group. Suite 987 East Pavilion Weds 4:30-5:15 pm.
- To schedule evaluations, have patients/families call 503-215-9396.

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