Maryland BHIPP
Identification and Management of Eating Disorders in Pediatric Primary Care

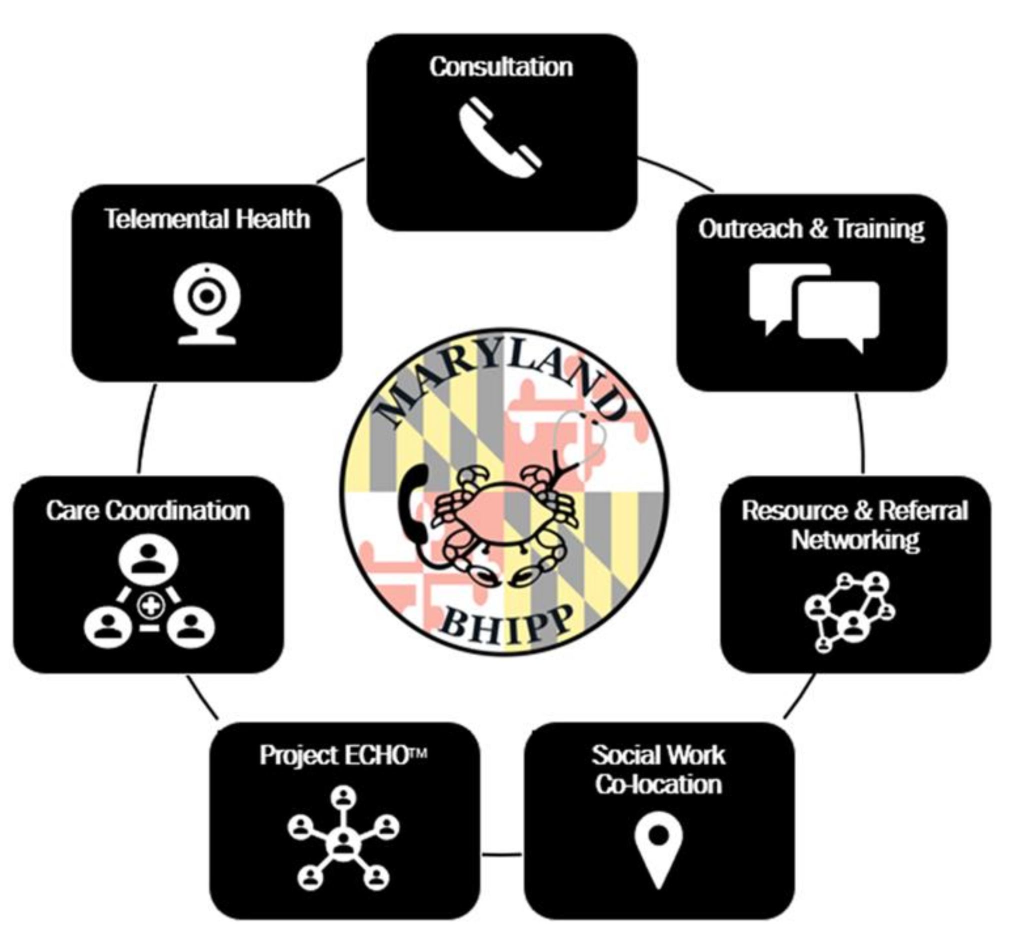
Thursday, February 18th, 2021 12:30 – 1:30 PM

Clinical Assistant Professor,
University of Maryland School of Medicine

855-MD-BHIPP (632-4477)

www.mdbhipp.org

Who We Are – Maryland BHIPP



Offering support to pediatric primary care providers through free:

- Telephone consultation (855-MD-BHIPP)
- Resource & referral support
- Training & education
- Regionally specific social work co-location (Salisbury University and Morgan State University)
- Project ECHO®

Coming soon!

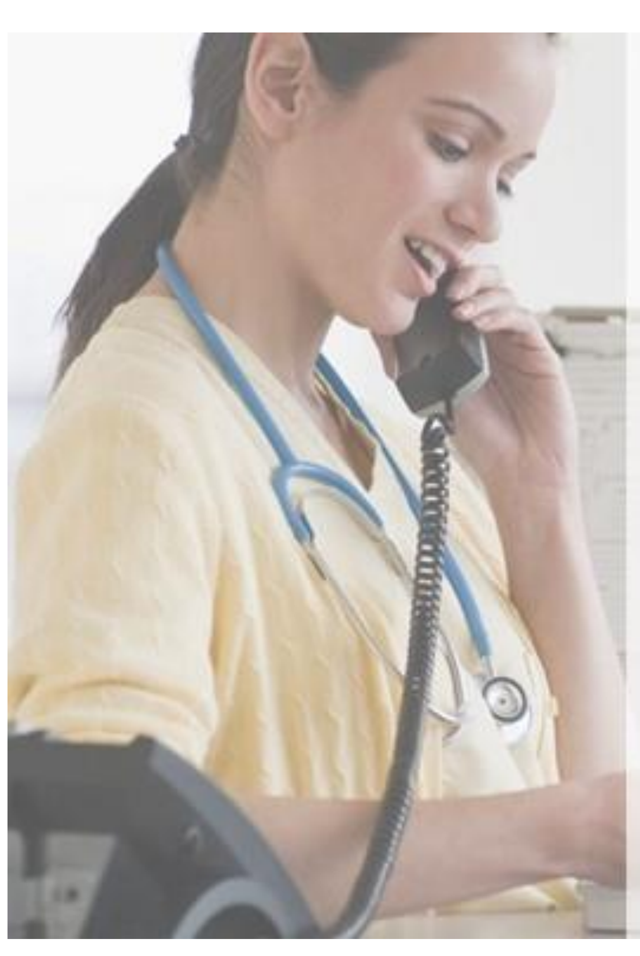
- Direct Telespsychiatry & Telecounseling Services
- Care coordination

Partners & Funding

- BHIPP is supported by funding from the **Maryland Department of Health, Behavioral Health Administration** and operates as a collaboration between the **University of Maryland School of Medicine**, the **Johns Hopkins University School of Medicine**, **Salisbury University** and **Morgan State University**.

- *This program is supported by the **Health Resources and Services Administration (HRSA)** of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $433,296 with approximately 20% financed by non-governmental sources. The contents of this presentation are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government. For more information, visit www.hrsa.gov.*

BHIPP is Available to Provide Support to PCPs During the Pandemic



BHIPP is open.

The BHIPP phone line remains open during this challenging time to support primary care clinicians in assessing and managing the mental health needs of their patients.

1-855-MD-BHIPP
(1-855-632-4477)

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Ways to Connect:

- **Visit our COVID-19 Resource Page:** www.mdbhipp.org
- **Sign up for our newsletter:** https://mdbhipp.org/contact.html
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Meet The Presenter

Shauna P. Reinblatt, MD is a Clinical Assistant Professor at the University of Maryland School of Medicine (UMDSOM), Department of Psychiatry, Division of Child and Adolescent Psychiatry. She is Board Certified in General Adult, Child & Adolescent, and Consultation Liaison Psychiatry. Prior to her becoming a psychiatrist, Dr. Reinblatt worked as a family doctor in Canada. She subsequently completed a General Psychiatry Residency at Northwell/Hillside Hospital and a Child and Adolescent Psychiatry Fellowship at NYU School of Medicine. She then pursued a research fellowship in pediatric psychopharmacology at the Johns Hopkins University School of Medicine.

Dr. Reinblatt has been a member of the full-time faculty at the Johns Hopkins University School of Medicine in the Department of Psychiatry for over a decade. During this time, she developed specialized clinical expertise working with children, adolescents, and adults with eating disorders in addition to her clinical child psychiatric work with youth.

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Identification and Management of Eating Disorders

- Identify warning signs for eating disorders
- Learn screening questions and screening tools for eating disorders
- Identify possible treatment plans to treat eating disorder patients and when to refer

Fictional Case

- Leah is a 14 year old girl; history of picky eating. No past diets. Has suddenly has cut out all sugar from her diet. Never eaten salads in the past and now is mainly eating salads.
- She weighs herself multiple times daily. She says she feels good at this weight (her BMI is 17 ; fallen of her growth curve).
- Goal is to lose weight as she does not want to be "fat" like her friend.
- She lacks energy and no longer enjoys reading or her favorite tv show.
- Refused to see an eating disorder therapist since she did not like seeing one last year so parents had not taken her back.

PUBLIC HEALTH IMPORTANCE of Eating Disorders

- Highest morbidity and mortality of pediatric mental health disorders (premature death).
- Highest risk of suicide of mental health disorders in youth (up to 18x compared with matched controls).

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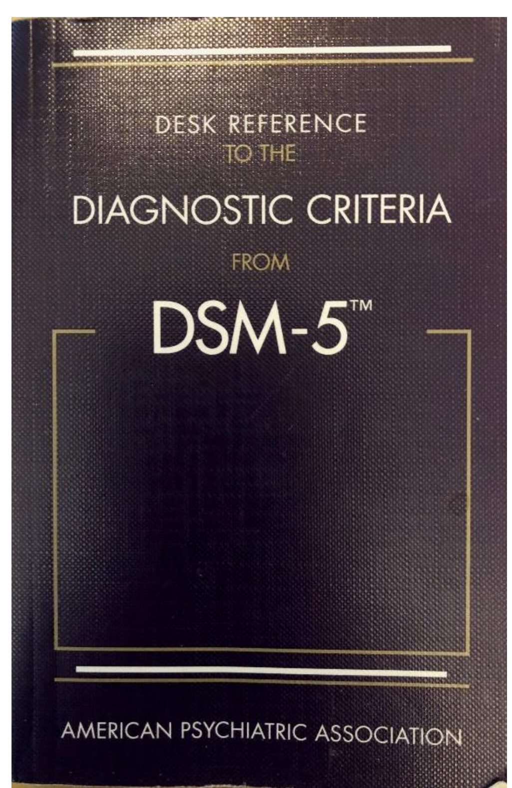
PREVALENCE (Adolescence)

- **BED** : Males 3.4%; Females 4.6% ----→1.6% overall
- **BN:** Males 0.5%; females 1.3%------→0.9% overall
- **AN:** Males 0.3%; Females 1% -------→0.3% overall

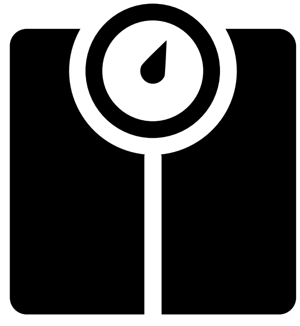
Swanson et al. Arch Gen Psych 2011 July

DSM-5 Eating Disorder Categories

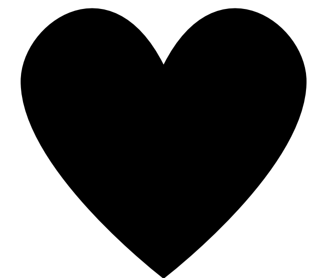
- **Anorexia Nervosa (AN)**
- **Bulimia Nervosa (BN)**
- **Binge Eating Disorder (BED)**
- Other Specified Eating Disorders (OSFED)
- Unspecified Eating Disorder
- Avoidant/Restrictive Food Intake Disorder (ARFID)



EVALUATION OF CORE SYMPTOMS



Weight



Shape

Anorexia Nervosa

- Restriction of intake leading to low body weight
- Intense fear of weight gain
- Undue influence of shape or weight

Bulimia Nervosa (BN)

- Binge: eating a large amount of food with loss of control
- Recurrent binges
- Compensatory behavior (purge, exercise laxative etc)
- Undue influence of shape or weight

Binge Eating Disorder

- Binge Behaviors
- No compensatory behaviors
- 3 or more associated symptoms:

Eating faster

Eating until uncomfortable

Eating large amounts, in absence of hunger

Eating alone, embarrassed

Feeling disgusted, depressed or guilty afterwards

PEDIATRIC EATING DISORDERS & PRIMARY CARE PEDIATRICS

Pediatricians are often the first to encounter youth with symptoms of eating disorders.

American Academy of Pediatrics suggests screening for eating disorders

AAP Policy statement Jan 2003 Pediatrics

Assessment

KEY WORDS:

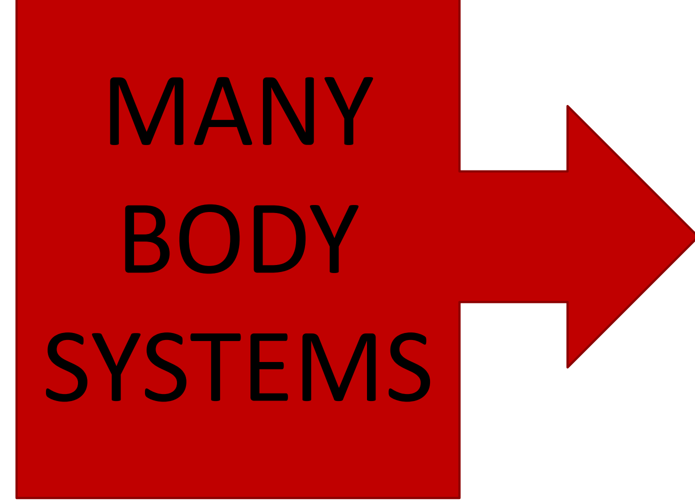
1. Healthy weight
2. Healthy choices
3. Physical Activity

FOOD LOGS :

1. Food
2. Eating behaviors

FOOD DIARY WEEK OF ______________							
	SUN	MON	TUE	WED	THU	FRI	SAT
BREAKFAST Time: _____							
SNACK Time: _____							
LUNCH Time: _____							
SNACK Time: _____							
DINNER Time: _____							
SNACK Time: _____							

MEDICAL COMPLICATIONS



- **Metabolic** – hypokalemia, hypoglycemia, hypophosphatemia
- **Cardiovascular** – bradycardia, hypotension, orthostasis
- **Musculoskeletal** – osteoporosis –
- **GI** – constipation, GERD
- **Endocrine** – amenorrhea, sick euthyroid
- **Immunologic** suppression
- **Neuro** – seizures due to water loading,

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Assessment

Safety -(medical and behavioral)

Weight and BMI

Hydration

Suicidal ideation….?

Labs – electrolytes

amylase?

BHCG

TSH

tox screen?

Other- EKG ? if electrolytic or cardiac concerns

Rosen DS; The American Academy of Pediatrics (AAP) Committee on Adolescence: Clinical Report—Identification and manage-ment of eating disorders in children and adolescents. Pediatrics. 2010;126:.

Quick behavioral screening questions:

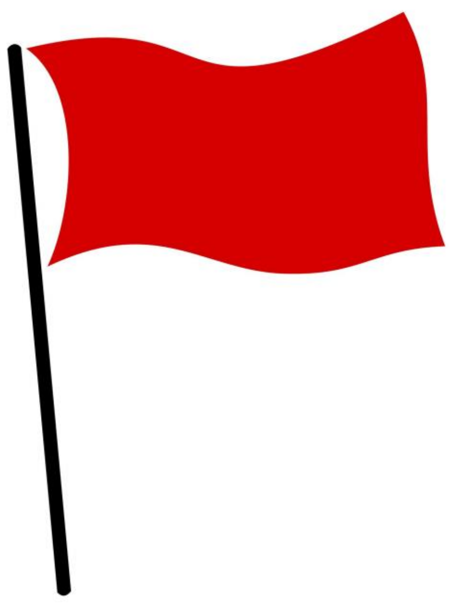
- What do you think should weigh?
- Do you think you ever eat more than anyone you are eating with (but you just can’t stop eating…)?
- Do you ever get rid of that food? Or take laxatives? Or exercise a lot?
- What you think of your body’s shape?
- Do you ever have trouble when you have to stop eating, like you lose control?

Differential ?

- Medical causes of weight fluctuation
- Medical causes of purging
- Substances>?
- Food insecurity
- Overeating?
- Comorbid psychiatric illness
    - OCD
    - Anxiety
    - Depression

RED FLAGS

- New reduction in intake or cutting out foods
- New intense exercise
- New lab work findings
- New physical exam findings
- New comorbid psychiatric complaints
- Preoccupation with weight and shape
- Sneaking food
- Eating alone or in secret



Other warning signs…

- Purging hints
- Interferes with future or current goals
- Behavioral changes?
- *Comorbid psychiatric symptom exacerbation*

SCREENERS

- SCOFF
- Eating Disorder Screen for Primary Care (ESP)
- Children's Eating Attitude Test (ChEAT)
- Children's Binge Eating Disorder Scale (C-BEDS)

SCOFF QUESTIONNAIRE:

Do you make yourself **Sick** because you feel uncomfortably full?
Do you worry you have lost **Control** over how much you eat?
Have you recently lost **> 1 Stone** (14 lbs) in a 3-month period?
Do you believe yourself to be **Fat** when others say you are too thin?
Would you say that **Food** dominates your life?

***Scoring*:** 1 point for every affirmative answer;
if >=2 possible Eating Disorder symptoms; warrants further evaluation

Morgan JF, Reid F, Lacey JH. The SCOFF questionnaire: assessment of a new screening tool for eating disorders. BMJ 1999; 319:1467.

Eating Disorder Screen for Primary Care (ESP)

1. Are you satisfied with your eating patterns?
2. Do you ever eat in secret?
3. Does your weight affect the way you feel about yourself?
4. Have any members of your family suffered with an eating disorder?
5. Do you currently suffer with or have you ever suffered in the past with an eating disorder?

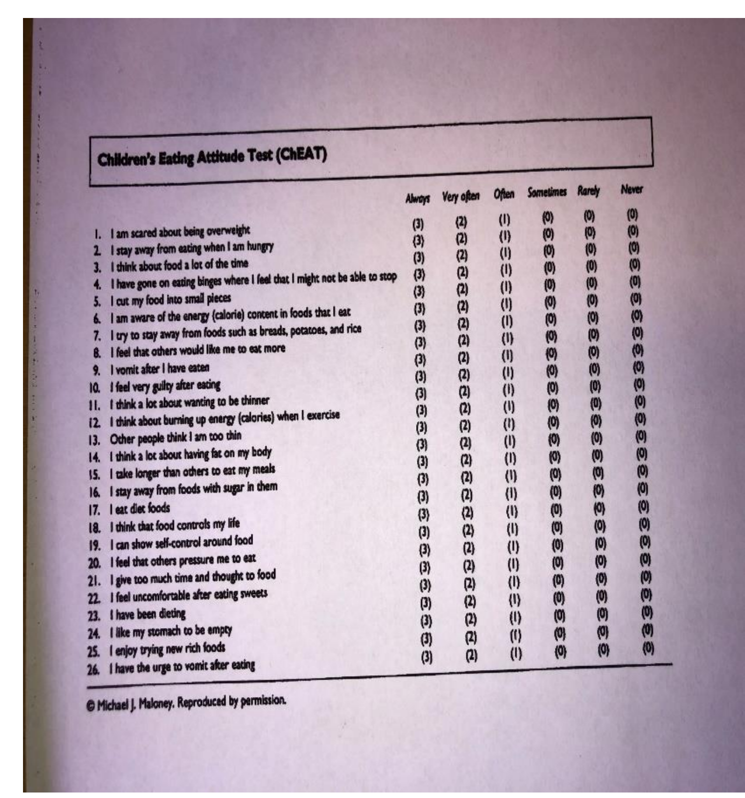
<u>*Scoring:*</u> *Affirmative screen = "no" answer for question 1 and "yes" answer for all other questions;*

If >=3 ->high likelihood of an Eating Disorder

Cotton MA, et al. Four Simple Questions Can Help Screen for Eating Disorders. J Gen Intern Med 2003.

Child Eating Attitudes Test (ChEAt):

- Self-administered assessment to screen for eating disorders in school aged kids and adolescents
- 26 items on a 6-point likert-type scale
- Questions about body image, preoccupation with food, dieting etc.
- Identifies issues that might be followed up further.



Children's Eating Attitude Test (ChEAT)

	Always	Very often	Often	Sometimes	Rarely	Never
1. I am scared about being overweight	(3)	(2)	(1)	(0)	(0)	(0)
2. I stay away from eating when I am hungry	(3)	(2)	(1)	(0)	(0)	(0)
3. I think about food a lot of the time	(3)	(2)	(1)	(0)	(0)	(0)
4. I have gone on eating binges where I feel that I might not be able to stop	(3)	(2)	(1)	(0)	(0)	(0)
5. I cut my food into small pieces	(3)	(2)	(1)	(0)	(0)	(0)
6. I am aware of the energy (calorie) content in foods that I eat	(3)	(2)	(1)	(0)	(0)	(0)
7. I try to stay away from foods such as breads, potatoes, and rice	(3)	(2)	(1)	(0)	(0)	(0)
8. I feel that others would like me to eat more	(3)	(2)	(1)	(0)	(0)	(0)
9. I vomit after I have eaten	(3)	(2)	(1)	(0)	(0)	(0)
10. I feel very guilty after eating	(3)	(2)	(1)	(0)	(0)	(0)
11. I think a lot about wanting to be thinner	(3)	(2)	(1)	(0)	(0)	(0)
12. I think about burning up energy (calories) when I exercise	(3)	(2)	(1)	(0)	(0)	(0)
13. Other people think I am too thin	(3)	(2)	(1)	(0)	(0)	(0)
14. I think a lot about having fat on my body	(3)	(2)	(1)	(0)	(0)	(0)
15. I take longer than others to eat my meals	(3)	(2)	(1)	(0)	(0)	(0)
16. I stay away from foods with sugar in them	(3)	(2)	(1)	(0)	(0)	(0)
17. I eat diet foods	(3)	(2)	(1)	(0)	(0)	(0)
18. I think that food controls my life	(3)	(2)	(1)	(0)	(0)	(0)
19. I can show self-control around food	(3)	(2)	(1)	(0)	(0)	(0)
20. I feel that others pressure me to eat	(3)	(2)	(1)	(0)	(0)	(0)
21. I give too much time and thought to food	(3)	(2)	(1)	(0)	(0)	(0)
22. I feel uncomfortable after eating sweets	(3)	(2)	(1)	(0)	(0)	(0)
23. I have been dieting	(3)	(2)	(1)	(0)	(0)	(0)
24. I like my stomach to be empty	(3)	(2)	(1)	(0)	(0)	(0)
25. I enjoy trying new rich foods	(3)	(2)	(1)	(0)	(0)	(0)
26. I have the urge to vomit after eating	(3)	(2)	(1)	(0)	(0)	(0)

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http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/ChEAT.pdf

Smolak L, Levine MP. Psychometric properties of the Children's Eating Attitudes Test. Int J Eat Disord. 1994 Nov.
Garner DM, et al. The eating attitudes test: psychometric features and clinical correlates. Psychol Med. 1982 Nov.

CBEDS (Shapiro et al 2006 IJED) Children's Binge Eating Disorder Scale

Advantages:

- Good as a quick screen for clinical work
- Can use in young children

Disadvantages:

- Does not contain frequency nor severity data
- Limited psychometrics

Scoring:

1 and 2 positive
And one positive of any of # 3, 4,or 5
And at least 3 weeks on # 6
And negative response on # 7

	ITEMS	YES	NO
1.	Do you ever want to eat when you are not even hungry?	1	0
2.	Do you ever feel that when you start eating you just cannot stop?	1	0
3.	Do you ever eat because you feel bad, sad, bored, or any other mood?	1	0
4.	Do you ever want food as a reward for doing something?	1	0
5.	Do you ever sneak or hide food?	1	0
6.	How long have you been doing this for? (transformed to weeks)	____ weeks	
7.	**Do you ever do anything to get rid of what you ate (for example by throwing up or pills to make you go to the bathroom)?**	1	0

TREATMENT and REFERRALS

- Per the AAP Policy Statement in 2003*, pediatricians have a role to play in treating the patient and monitoring refeeding– but also communicating with the team --- the nutritionist and therapist (and possibly psychiatrist).
- Explore family's concerns about ED treatment with specialists…
- Nutritionist
- Therapist experienced in EDs
- Psychiatrist..

*AAP Policy Statement – Identifying and Treating Eating Disorders; Pediatrics January 2003

Family Role Induction

- Involve all parents
- Dispel blame
- Firm but supportive limits
- Avoid splitting
- Keep a close eye on safety risks
- Need for a team approach (with PCP, parents and mental health therapist, psychiatrist and dietician etc).

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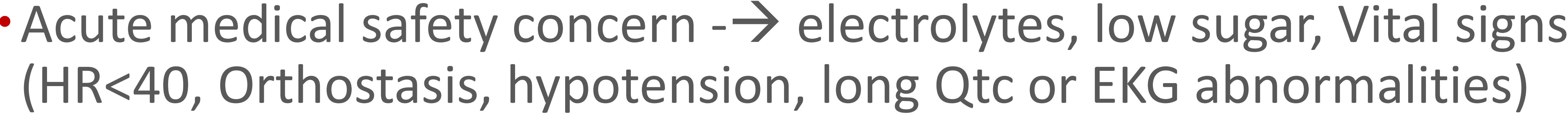
What LEVEL OF CARE?

1. Outpatient
2. Intensive Outpatient
3. Day Hospital
4. Residential
5. Inpatient Psychiatric
6. Inpatient Medical

INDICATIONS FOR HIGHER LEVEL OF CARE / HOSPITALIZATION

- Failure of outpatient treatment
- Weight loss (extreme or rapid)
- Acute food refusal
- Arrested growth and development



- Acute medical safety concern -→ electrolytes, low sugar, Vital signs (HR<40, Orthostasis, hypotension, long Qtc or EKG abnormalities)
- Acute psychiatric safety concern→ suicidal thinking, depression, obsessions)

Society for Adolescent Medicine Paper 2003

APA Practice Guidelines Eating Disorders and AACAP 2015 Practice Parameters

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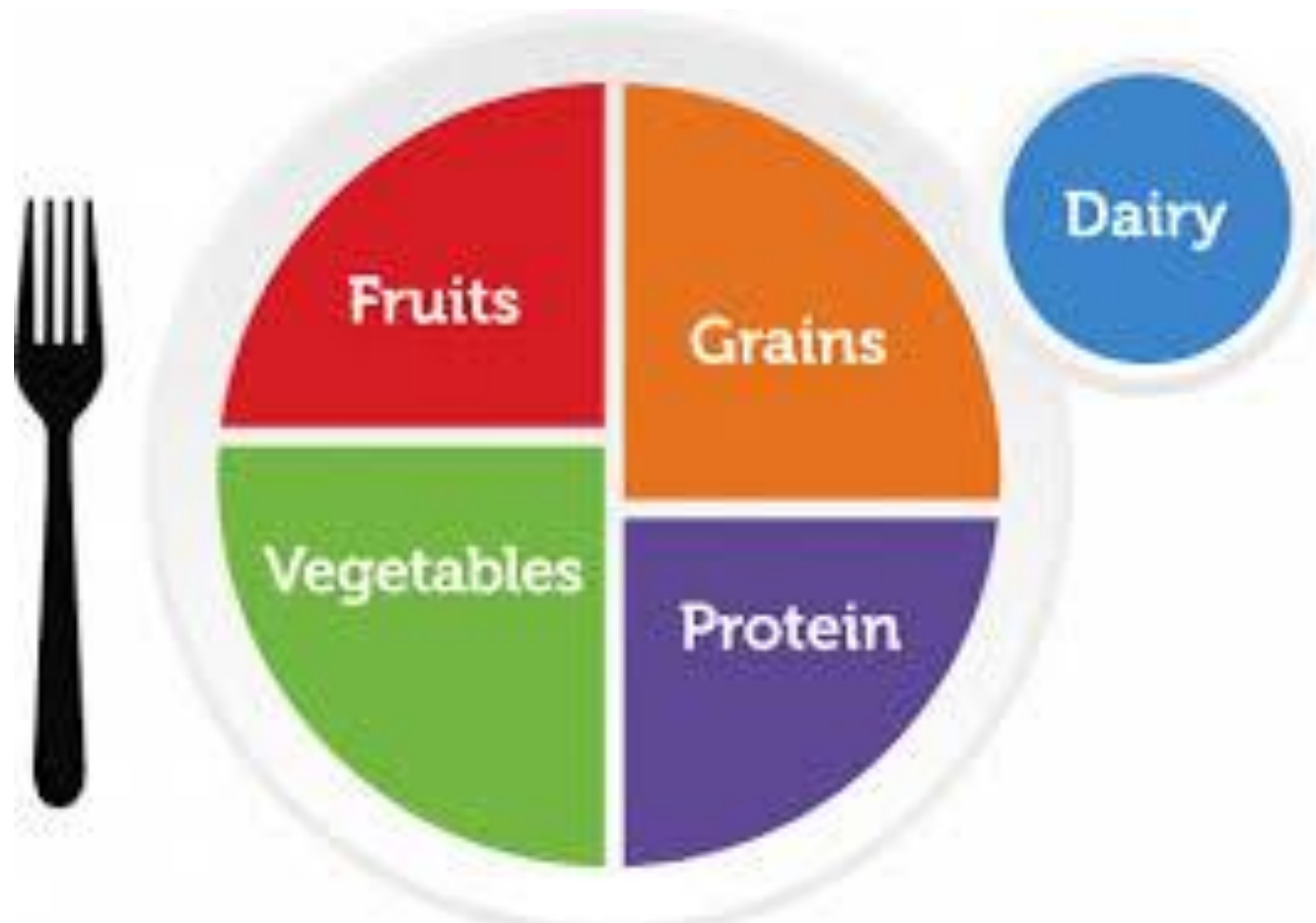
OUTPATIENT TREATMENT GOALS:

- Address ambivalence

- Helping the family who is in charge
- Regular meals, snacks
- Stop ED behaviors like binge/purging (depending on the specific disorder)
- Weight restoration if underweight (safe refeeding)
- Medical follow up (including weight)
- Meds for psychiatric comorbidities?

(once refed if low weight especially)

Nutritional Referrals?



- Refeeding as an outpatient
- Malnutrition
- Eating disorder symptoms (even if weight is not the focus)
- Medical comorbidities

Therapy for Youth with Eating Disorders…?

TYPE	TARGETS	EVIDENCE SUMMARY	RECS
FAMILY-BASED TREATMENT (FBT)	Supports parental management of behaviors	RCTs for AN RCTs for BN	USEFUL FOR MOST AN &BN CASES
COGNITIVE BEHAVIORAL THERAPY (CBT)	Manage distorted cognitions, fear of weight gain	1 RCT and 1 case study for BN No data for AN or BED in youth yet	May be useful for BN
INTERPERSONAL Psychotherapy (IPT)	Changing interpersonal relationships trigger behaviors	Data suggesting IPT helps limit excess weight gain in youth (binge eating)	May be useful for BED in adolescents

Family-Based Treatment

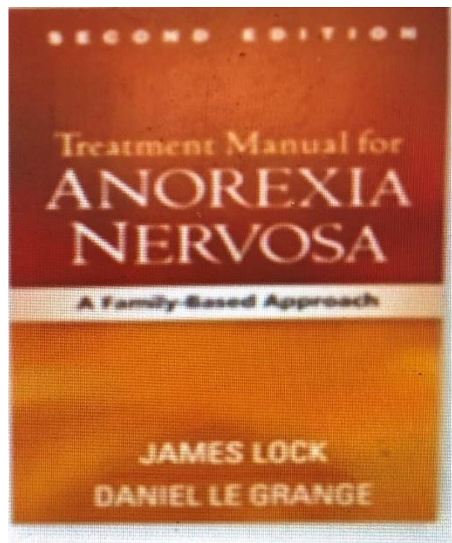
- A behavioral "real world" treatment
- Parental involvement
- Educate regarding ambivalence and relapse
- Limit setting with patient
- Charge parents with structuring mealtimes and diversifying food repertoire
- Consider a treatment contract as needed

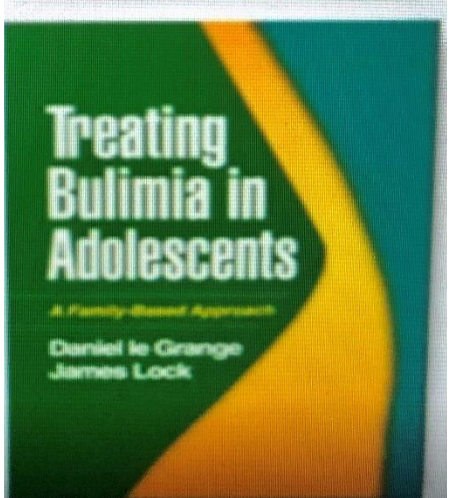
W

FBT (continued)

1. **Externalization**: The illness is responsible not the child.
2. **Focus**: Not on causation; focus on symptoms.
3. **Caregiver**: Responsible for supervising.
4. **Monitor:** Warning signs for the eating disorder.

FBT for AN & BN.





←**FBT Manuals** (Lock and LeGrange)

- **3 phases of FBT;**
- *PHASE 1:* Parents are tasked with renourishing child. Nutritionist consults to parents.
- Weekly sessions with all family members who must be aligned.

PHASE 2: The child begins to eventually regain some independence. Biweekly sessions. Gradual return to activity.

PHASE 3: Focus is recovery . Sessions are Child easts independently and try to help with adolescent issues.

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Some tips for feeding in Phase 1

- Parents are responsible for providing food, plating and serving it.
- 3 regular meals (some fat at all meals)
- Avoid diet foods (i.e. fat free, sugar free)
- Eat with family, not alone
- Monitor if bathroom breaks after eating
- Stop all exercise while on weight restoration

FBT (continued)

- Complete remission rate: only 38% --but no better treatment.
- FBT is first line for AN. 75% have some improvement in eating and weight pathology.
- FBT accelerates weight restoration and reduces inpatient admission ratees.

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COGNITIVE BEHAVIORAL THERAPY

Excessive importance of self-image (shape or weight)

Anxiety / stress or low mood

Purging

Inhibit purging behavior

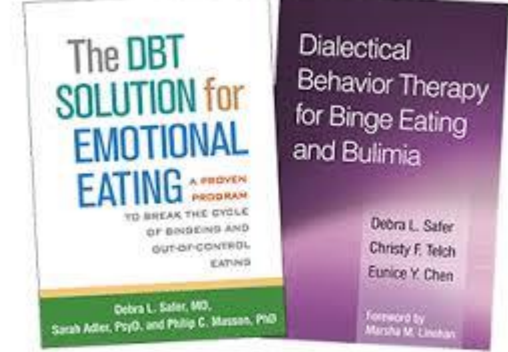
Habituation
Extinction Learning

THIS IS STRESSFUL/CHALLENGING!

Fairburn 1993

Dialectical Behavioral Therapy in Teenagers

- Uses mindfulness principles (plus CBT)
- Disconnection between thought and actions
- Growing evidence that DBT (short term) helps reduce eating and shape concerns and eating restriction in teenagers 13-17 years of age . (5 clinical studies; 2 with only BED some with mix of AN/BN and other eating disorders).
- Books by Safer et al re: Emotional eating
- and BED in adults ------



Omiwole M, et al. Review of Mindfulness-Related Interventions to Modify Eating Behaviors in Adolescents. Nutrients. 2019 Dec

Interpersonal Therapy to prevent excess weight gain

- Pilot study tested the feasibility of adapted version of group IPT for the prevention of excess weight gain (IPT-WG) vs. health education (HE) for adolescent girls (aged 12-17 years).

- Aims to improve interpersonal function and reduce negative affect therefore reduce LOC eating.

- Primary outcome:
- Attendance and adherence good
- Secondary outcome:
- At 1 year follow up there was less than expected BMI growth

- Tanofsky-kraff Int J ED 2010 43, 701

In children and adolescents with LOC eating or BED:

- Goal is to normalize eating behaviors as it is with other eating disorders.
- May first need to focus on bingeing to interrupt the binge cycle.
- Depending on BMI percentile, AAP recommendations for rate of weight loss and multidisciplinary programs.
- Depending on BMI percentile, may focus on prevention of excess weight gain rather than fast weight loss

General Strategies for Pediatric Binge-Eating Behaviors

- Diary of binges; identify binge patterns.
- Don’t skip meals
- Identify eating cues
- Do fun things to reward not bingeing or feeling guilty
- Learn alternate coping skills for emotional eating triggers

What about psychotropic medications?

- **SSRI**: Fluoxetine studied in adults up to 60 mg daily dose for BN. IN youth, only one uncontrolled trial (small) ; tolerated. May be useful for adolescents with comorbidity and second line for BN
- **NO BUPROPION** re seizure risk in ED patients.
- **MIRTAZAPINE?**

Pharmacotherapy

OLANZAPINE: *Most studied for AN in children and adolescents*

Target comorbidity and ED cognitions

- RCT with Small effect in study (N=23); 15 got the treatment.
- Recommended very low dose (0.625-1.25 mg daily) and specialty consultation[up to max 5 mg daily

ABILIFY – some case series

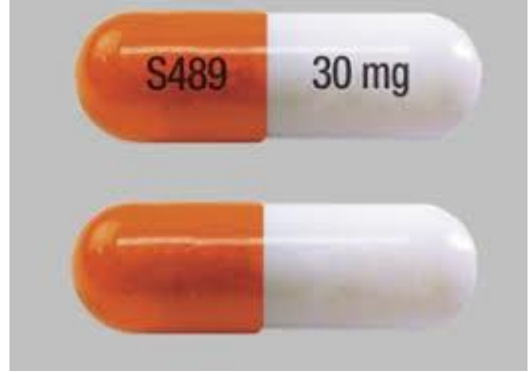
(0.5-1 mg TDD with trained professional

Max 2 mg Daily dose

Canadian guidelines Couturier Feb 2020; AACAP ED Practice Parameters 2015

Meds?

- **Lisdexamfetamine** : Adult studies in BED and adult indication for lisdexamfetamine but no data specifically for kids yet.



- **Treat comorbid psychiatric illness--** keeping in mind the weight of the patient re: malnutrition status and risk of QTc prologation.

- PCPs play an important role to screen for pediatric eating disorders and to refer.
- Eating disorders typically feature some combination of eating and shape concerns (clinical screening or via screener questionnaires).
- Establishing medical safety and renourishing the patient is the first step, and then deciding the level of care.
- FBT has the best evidence to support its’ use in AN and BN and is often used in outpatients.
- Normalizing eating behaviors is the first step in BED; with growing evidence for DBT and IPT.
- Limited evidence for medication use in children.

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Thank you!

Questions?