Welcome

Rogers treats children, adolescents and adults with:

• OCD and anxiety disorders
• Depression and mood disorders
• Eating disorders
• Addiction

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Child and Adolescent Eating Disorders: Thinness Storm – Current Triggers

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School Mental Health Institute
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Disclosures

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Learning Objectives

At the end of this presentation, participants will be able to:

1. Understand the different eating disorders seen in children and adolescents based on the DSM-V.
2. Understand the prevalence of eating disorders among children and adolescents.
3. Identify signs and symptoms of an eating disorder in children and adolescents.
4. Identify and understand causes, stressors, and triggers for eating disorders.
5. Identify prevention and intervention strategies for triggers within your schools.
6. Ideas on how to battle weight stigma in your schools.
Eating Disorders in Children and Adolescents

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Avoidant Restrictive Food Intake Disorder
- Disorders of Feeding and Eating
  - Pica
  - Rumination Disorder

Diagnostic Criteria for Eating Disorders

Anorexia Nervosa

- Restriction of energy intake relative to requirements leading to significantly low body weight (or for children failure to make expected weight gains)
- Intense fear of gaining weight or persistent behaviors that interfere with weight gain
- Overevaluation of thinness, disturbance in way body is perceived, lack of recognition of seriousness of low body weight
  - Subtypes:
    - Restricting
    - Binge Purge
Diagnostic Criteria for Eating Disorders

- **Bulimia Nervosa**
  - Recurrent episodes of binge eating
    - Eating a large amount of food in a discreet period of time
    - A sense of lack of control while eating
  - Recurrent inappropriate compensatory behaviors to prevent weight gain
  - Binge/purge episodes once/week for 3 months
  - Overvaluation of thinness

- **Binge Eating Disorder**
  - Recurrent Episodes of Binge Eating
  - Binge associate with three of the following:
    - Eating more rapidly than normal
    - Eating until feeling uncomfortably full
    - Eating a large amount when not physically hungry
    - Eating alone due to embarrassment about eating
    - Feeling disgusted with oneself, depressed, or guilty afterwards
  - Binge occurs once/week for three weeks
## Diagnostic Criteria for Eating Disorders

### Avoidant/Restrictive Food Intake Disorder (ARFID)
- Eating disturbance (lack of interest in food, avoidance based on sensory characteristics, concern about adverse consequences of eating) that results in failure to meet nutritional needs associated with at least one of:
  - Significant weight loss or failure to make expected weight gains
  - Significant nutritional deficiency
  - Dependence on enteral feeding or nutritional supplements
  - Interference with psychosocial functioning
- Does not meet criteria for AN/BN

### Other Specified Feeding or Eating Disorder
- Atypical Anorexia
- Subthreshold Bulimia Nervosa
- Subthreshold Binge Eating Disorder
- Purging Disorder
- Night Eating Syndrome
Eating Disorder Prevalence

- According to US estimates from the National Institute of Mental Health, between 5 and 10 million girls and women and 1 million boys and men suffer from eating disorders, including anorexia, bulimia, binge eating disorder, or other associated dietary conditions.

- Eating disorders are now the third most common chronic illness in adolescent girls (Pediatrics and Child Health 1998 3(3) 189-92).

Eating Disorder Prevalence

About 3 percent of U.S. adolescents are affected by an eating disorder, but most do not receive treatment for their specific eating condition, according to an NIMH-funded study published online ahead of print March 7, 2011, in the Archives of General Psychiatry.
What the research says:

Studies consistently demonstrate that adolescents' body comparisons are strongly associated with unhealthy weight-related attitudes and behaviors.

What the research says:

- According to the data, 0.3 percent of youth have been affected by anorexia, 0.9 percent by bulimia, and 1.6 percent by binge-eating disorder. The researchers also tracked the rate of ED-NOS (now ARFID), a catch-all category of symptoms that do not meet full criteria for specific disorders but still impact a person’s life. This is the most common ED diagnosis. Overall, another 0.8 percent had subthreshold AN, and another 2.5 percent had symptoms of subthreshold binge-eating disorder.
What the research says:

- ED NOS is the most common outpatient diagnosis we see, but yet because it is not AN or BN people ignore or minimize the severity.

What the research says:

- Hispanics reported the highest rates of bulimia, while Whites reported the highest rates of anorexia.
- The majority who had an eating disorder also met criteria for at least one other psychiatric disorder such as depression.
- Each eating disorder was associated with higher levels of suicidal thinking compared to those without an eating disorder.

In practice:

We recognize eating disorders do not stand alone, and we strive to identify and treat the co-morbidity on our unit. Eating disorders do not discriminate among race, ethnicity, or social classification.

We are also seeing a greater number of patients with anxiety, OCD, and depression within our programs. We currently have behavioral specialists at all levels of care at RMH to help individualize their treatment, develop hierarchies, and work on exposures to their specific needs.


What the research says:

- Eating disorders represent a major public health concern – role impairment, SI, co-morbid disorders, medical problems.
- Findings clearly underscore the need for better access to treatment specifically for eating disorders.
- And, more specifically for treatment of eating disorders for children and adolescents.

So, what are we seeing in children and adolescents?

Increasing concerns with weight-related issues in children at progressively younger ages:

- 42% of 1st – 3rd grade girls want to be thinner
- 45% of boys and girls in 3rd – 6th grade want to be thinner
- 37% of elementary schoolers have dieted
- 51% of 9-10 year old girls feel better about themselves when dieting

Eating Disorders among Younger Populations

- 9% of 9 year olds have vomited to lose weight
- 81% of 10 year olds are afraid of being fat
- 53% of 13 year old and 78% of 18 year old girls are unhappy with their bodies
Eating Disorders and Boys

• Growing awareness of the presence of eating disorders in males
• Statistics historically show about 5-10% of child and adolescent ED cases are males
• Need for more multi-center studies
• Sports
• Muscle vs. fat
• Identity Issues

Signs & Symptoms: Emotional

• Change in attitude/performance
• Expression of body image complaints/concerns
• Talking about “dieting” – avoiding “fatty” foods
• May be overweight, eats small portions in front of others
• May be a target of bullying due to body or weight
• Spends increasing time alone
• Denies having difficulty in daily life
Child and Adolescent Eating Disorders: Current Triggers

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Signs & Symptoms: Emotional

- Obsession with maintaining low weight for sports, modeling, dance, acting
- Overly self-sufficient – will not ask for help
- Mood: labile and/or depressed
- Body image dissatisfaction
- Preoccupation with weight, body shape and/or appearance

Signs & Symptoms: Cognitive

- Poor nutrition may have detrimental effects on the normal functions and development of the brain and the body
- Eating disorders can have a profound impact on a child’s cognitive abilities and learning at school:
  - Poor concentration
  - Slowed thinking
  - Change in poor performance:
    - Either a drop in grades or sometimes an improvement in academics
    - Poor impact on school behavior: irritability
    - Poor attendance

NEDA

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### Signs & Symptoms: Behavioral

- Dieting, chaotic food intake – skipping meals, pretending to eat, throwing food away
- Exercising excessively
- Increase in conversation about food
- Frequent trips to the bathroom
- Wears very baggy clothes to hide a thin body or weight gain; hide a “normal” body because of disordered thoughts about body shape/size
- High anxiety, particularly at meals
- Perfectionism: studying in library during lunch
- Significant amount of time in front of mirror and a strong focus on appearance
- Clothing (layering, baggy, change in style)
- Avoidance of cafeteria and/or foods (most likely those higher in calories and fat)
- Carrying own food at school
- Compulsive behavior
- Frequently reading books about eating disorders
- Vegetarianism
- Lies and manipulation around food and exercise
- Negative self-talk about one’s body, appearance, weight
- Is the frequent target of weight/body shape ridicule by peers

### Eating Disorder Behaviors

- Misuse of condiments (dipping bread in salt)
- Combining foods or not eating foods if they have touched one another
- Rapid or slow eating (< 15 minutes or > 45 minutes)
- Rituals (eating in a specific order)
- Chewing and spitting out food
- Something for nothing
  - Caffeine (soda, coffee, tea)
  - Sugar substitutes and diet foods
  - Gum
  - Breath mints
  - Candy
  - Cough drops
  - Veggie loading
- Cutting up food into small pieces
- Getting up and down several times during meals
- Anxiety (shaking legs, no eye contact, no conversation, etc.)
- Excessive chewing
- Odd utensil use (fork for yogurt)
- Only safe foods (fruits, veggies, yogurt, etc.)
- “Snacks” at meals
- “Allergies”
- Excessive liquids or restricting liquids
- Hiding food (pockets, sleeves, etc.)
Unfortunate reality…

“1 in 10 cases of Anorexia Nervosa lead to death from starvation, cardiac arrest, or suicide”.

NIMH

Causes

Vulnerable time period:
- Emerging puberty/puberty
- Sexual identity issues
- Social development
- School/Academic Pressures
- Sports involvement and pressures
- Family Stressors
- Medical Stressors
Causes

• The perfect Storm

• Biological
  – Increased rates among family members who have had an eating disorder
  – Biological changes in puberty

• Psychological
  – Comorbid anxiety disorders, depression, and other mental illness

• Social
  – Thin and nutrition obsessed culture, family stressors, etc.

Stressors: Pressure to Exercise

• Promotion of daily exercise in the media/school:
  – I am the FIT generation (pamphlet/program sponsored by mptv)
  – Focus on “healthy eating” and daily exercise as “challenges”.
  – Play 60 (NFL)
  – Coaches pushing kids to work harder (even endorse ED behaviors).
**Stressors: Nutrition and Health Class**

- Health class/nutrition classes — are we thinking of the potential risks and benefits to teaching about nutrition and eating disorders?
- Can we simultaneously treat obesity and eating disorders?
  - Must be aware of kids at both spectrums and how they may or may not be affected by the material being taught.
  - Must be careful when addressing eating disorders and weight issues in the classroom:
    - May trigger individuals
    - May teach kids behaviors they do not need to know
    - May be embarrassing

**Girls**
- Slight weight increase
- Adipose tissue increase
- Breast bud/breast development (takes 3-4 years).
- Hormonal changes
- Hips broaden
- Hair growth
- Growth spurt 8-12 years of age
- Head, hands, and feet are the first parts to reach mature size
- Girls lose less of their body fat than boys, giving them a rounder appearance
- Girls may begin pubertal changes at ages 8 to 16

**Boys**
- Genital changes
- Hair growth
- Fat tissue in chest
- Within one year expect growth spurt (height)
- Shoulders will broaden making hips and waist look smaller
- Increase in muscle mass
- Boys begin as early as 10 or as late as 18
THE #1 WISH OF 11 TO 17 YEAR OLD GIRLS IS: “TO LOSE WEIGHT”. 

Triggers

**Definition of Triggers**

- Defined: certain instances which contribute to the rise of an ED; these events alone do not cause EDs but may increase rate of onset and worsen one’s current condition.
- Triggers do not discriminate and are individualized to each person.
- What are the typical triggers?

**Common Triggers:**

- Perfectionism
- Bullying
- High expectations for achievement and success
- Low self-esteem
- Stress
- Anti-obesity or MD comments
- School – focus on healthy eating
- Medical Illnesses
- Exposure to Media
- Abuse/Trauma
- Family places too much value on appearance, school, sports
Empirical Data (2011)

- Based on qualitative investigation into 239 patient charts.
- Reviewed multiple pieces of data including demographics, sex, diagnosis, GAF, trigger for eating disorder, length of stay, and referral information.

Real life Triggers

[Graph showing various triggers such as Unrevealed, School, Desire to lose weight, Family related, Medical, Peer issues, Outliers, Identity Issues, and Sexual Assault]
Difficulty Specifying Trigger

- Unspecified or not specific:
  - no trend in age; ranged from ages 8 to 17
- Trigger may be identified further into treatment, or may go unidentified (specifically with the younger population).

School Triggers

- Multiple issues presented regarding school including the following triggers:
  - Stress of academics
  - Bullying
  - Teacher comments
  - Nutrition/Health room class information
Medical Triggers

- The following showed to be medical triggers:
  - Fractures
  - Mono (Frequent Strep infections)
  - Being “sick” to get attention
  - Constipation (History of GI problems)
  - History of Allergies (food mainly) and Intolerances

Triggers leading to desire to lose weight

Triggers in this category include:
- Weight loss that got “out of control”
- Poor Body Image
- Orthorexia
- Comparing to relatives, classmates
- Few references to media
- Vegetarian/Vegan diet change
**Sports Triggers**

- 50% males 50% females reporting sports as triggers
- Typically included injuries during sports or “not making a team”
- Pressure from coaches
- Sports included:
  - Ballet
  - Wrestling
  - Volleyball
  - Track/Cross Country

**Family Triggers**

- Parents not on the same page
- Divorce
- Competition within the family
- Family life style
- Parental mental health concerns
  - Eating disorders
  - Substance abuse
  - Sexual abuse
**Relationship Issues**

- All four reported were from females
- All reported having a “bad break-up” or boyfriend moving
- One reported maturation fears prior to eating disorder

**Friends/Peers Triggers**

- All female reporting friend/peers as primary trigger
- Intense comparing of self to others
- Developing ED together
- Being “triggered” in treatment at different levels of care reported
### Trauma

- Including sexual assault, parent passing away, no contact with a bio-parent
- Reported by females
- Range of AN and BN behaviors

### Identity Issues Triggers

- Punishing self – binge/purge/restrict
- Feelings of not deserving food/water
- History of being bullied for appearance, identity choices
- High SI
- Males and females both affected
Outlier Cases

- 25% male cases
- Triggers identified as:
  - Fears of choking post incident
  - r/o psychosis
  - Fear of vomiting

Unrevealed Triggers

- This is the largest group in the study. Due to this, we now have patients and parents answer this question specifically.
- The answer may not have been found in the chart
- Patients may not know their trigger until much later in treatment
- Ultimately treatment is the same
Other Important Triggers: Media

Exposure to media
- bombardment with ads for weight-loss methods, overly thin women in media
- weight loss apps
- pro-eating disorder web sites

Internet
- Images, celebrities, ability to order weight loss medications online, etc...

Other important Triggers: Youth Sports

- Youth sports either knowingly or unknowingly produce, allow, push, and even protect eating disorders.
- This is a dangerous game!
- Athletics/competitive teams; swimming coach barking to swim harder, faster, doing extra laps; misperception that being thinner will lead to faster running; pressure from coach to stay thin
Vignettes

Prevention

Educate, educate, educate!

- Educate primary care physicians on how to treat obesity and eating disorders simultaneously (it cannot be all or nothing).
- Educate our educators: health room and nutrition classes must be very careful! What they believe is helping these kids as actually giving them tools to hurt themselves.
- Educate our coaches: “fine” is good enough! Discuss with coaching staff to stop the comments about body weight, shape, and size. To allow the kids to have fun and play the sport! These kids push themselves too much already – it is just adding fuel to the fire.
**Prevention**

Last but not least — and certainly most important! — is this:

**Educate our parents!**

- Promote family meals several times per week despite busy schedules
- Start early — do not allow major negotiations on food at a very young age — nor promote the “clean plate club”.
- Do be the parent — it is okay to say no, follow your gut, and get help if you feel something is not right with your child.

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**10 Ways to Battle Weight Stigma in Schools**

- The following interventions stem from the annual Weight Stigma Awareness Week that took place the last week of September 2014.
- There was a special focus on September 25\(^{th}\) on the issue of weight stigma in school settings.
- A recent press release by the Academy for Eating Disorders precipitated the above.
- The AED announced: half of children’s TV programs contain at least one weight-stigmatizing event.
- The problem of weight stigma among youth is ever more pertinent!

Article from a link on NEDA.org written by Elizabeth Claydon — New Haven Coach Examiner: [http://www.examiner.com/list/ten-ways-to-battle-weight-stigma-schools](http://www.examiner.com/list/ten-ways-to-battle-weight-stigma-schools)
10 Ways to Battle Weight Stigma in Schools

• 1st – realize that it exists.
• Weight bias leads to weight stigma.
• Children are more conscious that they judge and are judged on their weight.
• Children often assume they will be judged on their weight (picked last for a team/excluded from the popular crowd).
• But, they do not realize it is an unacceptable form of oppression.

10 Ways to Battle Weight Stigma in Schools

• 2nd: Stop teaching it.
• In order to stop weight stigma, we must stop teaching it.
• Sometimes it slips subconsciously into our assumptions and discussions – especially when talking about health.
• We need to be careful with our words and actions.
10 Ways to Battle Weight Stigma in Schools

- 3rd: Stop having us calculate our BMI in health/gym/psychology class and telling us what’s ok and what’s not ok!
- BMI is NOT a perfect tool – but many rely on it clinically.
- BMI does not indicate a person’s health (especially not a child’s when their body is still growing and changing at a rapid rate).
- Calculating BMI in classrooms and providing reports to parents only transmits undo competition and a distorted an unhealthy view of the importance of weight and body image.

10 Ways to Battle Weight Stigma in Schools

- 4th: Teach Health not Weight:
  - Health must be the focus instead of weight.
  - It would behoove us to NOT teach BMI in school and leave it to the pediatrician to discuss with parents and their children as it is only a fraction of what makes someone “healthy”.
  - We need to be teaching health and wellness – physical, emotional, and spiritual.
10 Ways to Battle Weight Stigma in Schools

- 5th: School staff should be aware of their own body-negative comments:

- Children and teens are a vulnerable population and highly susceptible to the influence of their peers, families, and school staff.

- If we are in the position of influence over children we MUST recognize our own biases and insecurities to be sure we do not project them.

10 Ways to Battle Weight Stigma in Schools

- 6th: How are Athletics Valued?

- Are athletics over emphasized in relation to other activities in your schools? Meaning that other activities like art, academic, or clubs are less valuable.

- Children and teens have talents in MANY areas – let’s value all of them!

- Also – if your students are in athletics – how does the coach or the team handle weight-related issues? Do they know how to identify unhealthy behaviors?
10 Ways to Battle Weight Stigma in Schools

7th: Look at the way schools institutionalize thinness as an accolade:

- The thin-ideal is so ever present in all areas of society – and school is no exception.
- It is up to us to begin a cultural shift beginning with the way we view and approach size in our schools – and all areas of our lives.
- Weight-biased bullying is a HUGE problem that can lead to life-long difficulties.

8th: Give us a chance to be activists:

Children and teens have a unique voice to harness their power to effect change.

They must be educated on the dangers of weight bias and stigma from a young age.

They need to understand the importance of changing the conversations.

If we allow them to use their power to change weight stigma they will not have to accept it as a natural part of life.
10 Ways to Battle Weight Stigma in Schools

• 9th: We need a safe way to practice our skills
• It is very difficult for children and teens to “speak up” about sensitive topics in a school setting.
• We must provide them with the opportunities to discuss weight stigma and bias in a safe place and manner.
• This may stimulate great discussion and brainstorming ideas on how to promote change.

10 Ways to Battle Weight Stigma in Schools

• 10th: We need to be taught to value difference – not fear it:
• It is so important that we embrace differences among our children and teens – not judge them.
• Weight continues to be considered an acceptable form of discrimination among adults and youth.
• We need to challenge this and respect one another for the exceptional individuals that we are – no matter what size, shape, or weight!
Questions?

References

Medical Management of Eating Disorders 2nd Edition by C. Laird Birmingham and Janet Treasure

Eating Disorders: A Guide to Medical Care and Complications 2nd Edition by Philip S. Mehler, MD and Arnald E. Andersen, MD

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- Google Images

Thank you

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- Oconomowoc
- Milwaukee (West Allis)
- Madison

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