Navigating adolescent eating disorders Key insights and challenges

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I have no financial disclosure

Learning Objectives

Review current trends and the prevalence of eating disorders.

Discuss applying a weight-inclusive approach when addressing health behaviors.

Identify clinical signs and symptoms that require further evaluation.

Describe different levels of care and key milestones in the recovery process.

Eating disorders

3rd most common chronic condition in adolescents

Every 52 minutes at least 1 person dies as a direct result of an eating disorder

Many start in childhood or early adolescence

Affect persons of all genders and gender identities, all ethnicities and socio -economic backgrounds

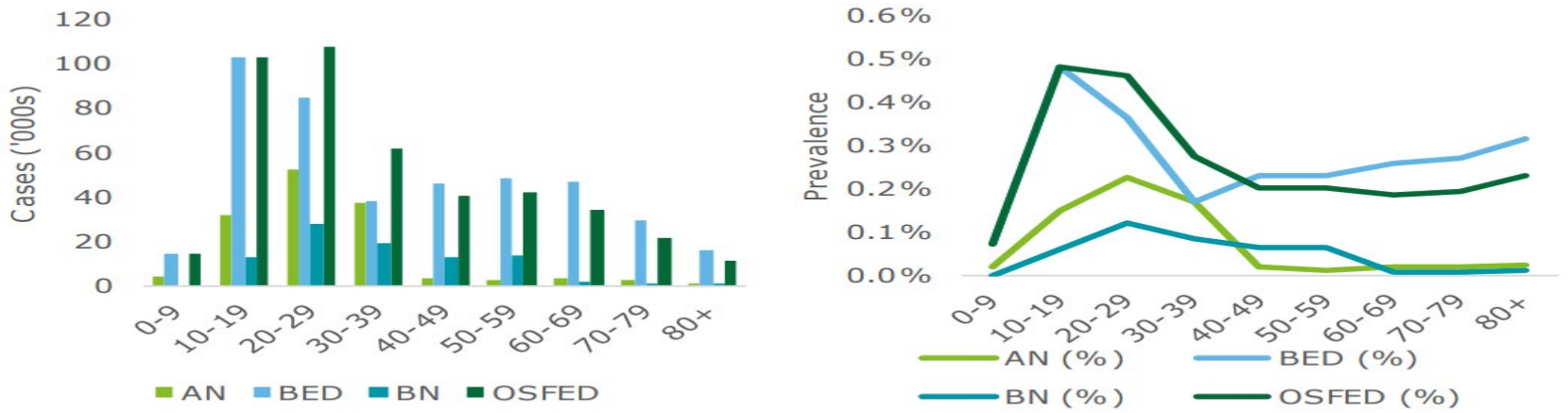
Estimate prevalence 6%-8% of adolescents, median age of onset is 12 years

Anorexia nervosa has 2nd highest mortality rate

Youth at higher weights have increased risk of having an eating disorder

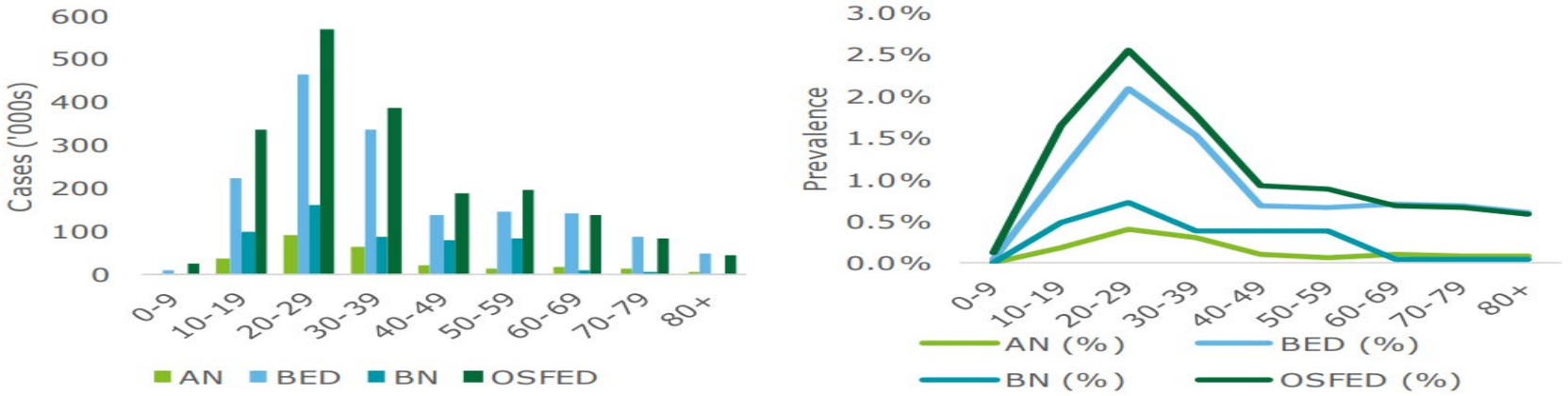
Prevalence of Eating disorder

Chart 2.1: One-year prevalence of EDs among males, by age (in years) and condition, 2018-19



Source: Deloitte Access Economics calculations based on Udo and Grilo (2018), Galmiche et al. (2019), Alegria et al. (2016), Glazer et al. (2019), Rozzell et al. (2019), Ward et al. (2019).

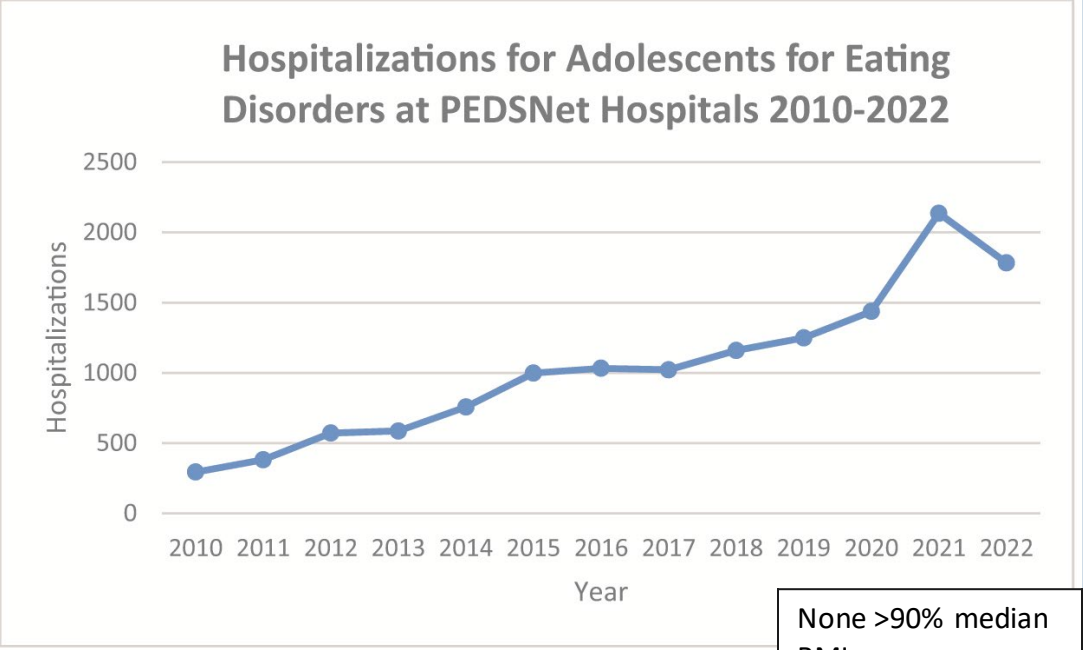
Chart 2.2: One-year prevalence of EDs among females, by age (in years) and condition, 2018-19



Source: Deloitte Access Economics calculations based on Udo and Grilo (2018), Galmiche et al. (2019), Alegria et al. (2016), Glazer et al. (2019), Rozzell et al. (2019), Ward et al. (2019).

From: **Clinical Characteristics of US Adolescents Hospitalized for Eating Disorders 2010–2022**

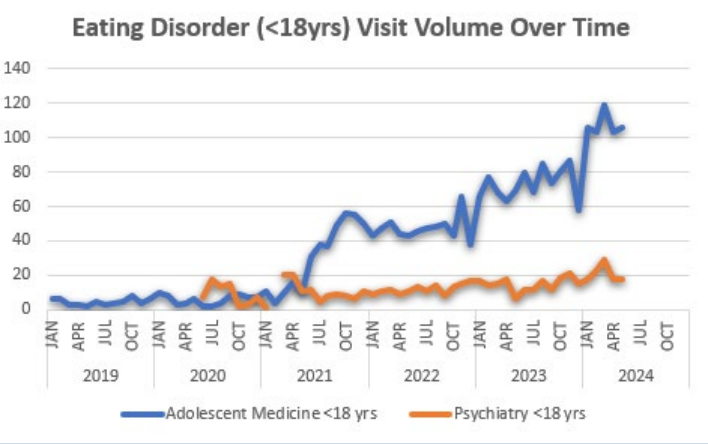
Hosp Pediatr. 2023;14(1):52-58. doi:10.1542/hpeds.2023-007381

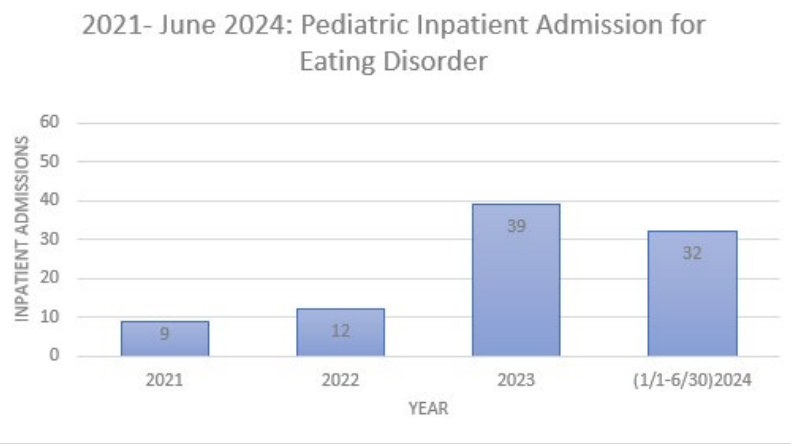


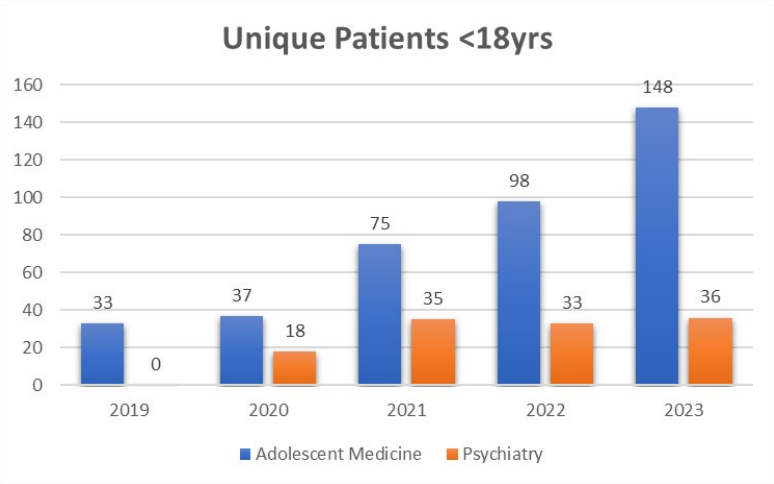
None >90% median BMI	3451 (50.9%)
Mild 80-90%	1697 (25.0%)
Moderate 70-80%	1262 (18.6%)
Severe <70%	368 (5.4%)

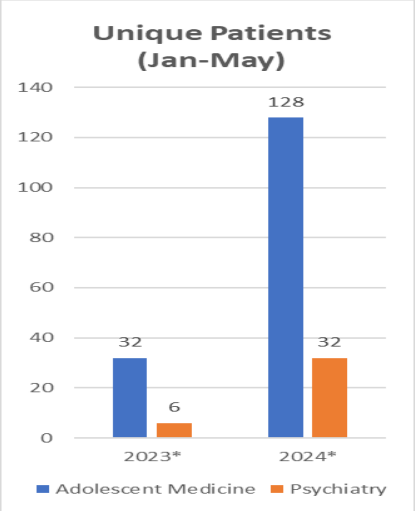
Figure Legend:

Hospitalizations for adolescents for EDs at PEDSNet hospitals 2010 to 2022 (data listed in Supplemental Table 2).









Inpatient and Ambulatory visit volume

Eating Disorders

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Other specified feeding or Eating disorder
- Avoidant/Restrictive Food Intake disorder
- Un-specified Eating disorders

Eating disorder co-morbidities

Anxiety/Depression 65 -70%

Obsessive compulsive disorder: 40%

Substance use disorder: 25%

PTSD:40-60%

ADHD:20%

Personality disorders:30-50%

Concurrent treatment of eating disorder and mental health co - morbidity is essential

Anorexia Nervosa

Refusal to maintain a body weight expected for height and age; failure to gain weight during a period of growth with body expected for height and age.

Intense fear of gaining weight or becoming fat

A disturbance in the way one's body weight or shape is experienced; denial of the seriousness of low body weight; an undue influence of body weight or shape on self-evaluation.

Source – DSM V

Bulimia nervosa

Eating an amount of food in a discrete period of time (2 h) that is definitely larger than most people would eat;

Recurrent inappropriate compensatory behaviors such as self-induced vomiting, misuse of laxative, diuretics, enemas, or other medications; fasting; or excessive exercise

Binge eating and inappropriate compensatory behaviors occur, on average, twice weekly for the previous 3 months

Unduly influenced by body shape and weight

Source – DSM V

Binge Eating Disorder

A. Recurrent episodes of binge eating.

B. Associated with three (or more) of the following:
   1. Eating much more rapidly than normal.
   2. Eating until feeling uncomfortably full.
   3. Eating large amounts of food when not feeling physically hungry.
   4. Eating alone because of feeling embarrassed by how much one is eating.
   5. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

D. **The binge eating occurs, on average, at least once a week for 3 months.**

E. **The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.**

Source – DSM V

Other specified eating disorder

Atypical anorexia nervosa(Met all criteria except weight is within or above normal range)

Bulimia nervosa (of low frequency and/or limited duration):

Binge-eating disorder (of low frequency and/or limited duration):

Purging disorder: Recurrent purging behavior in the absence of binge eating.

Night eating syndrome:

- ✓Recurrent episodes of night eating such as eating after awakening from sleep or after the evening meal.
- ✓ There is awareness and recall of the eating.
- ✓Causes significant distress and/or impairment in functioning.
- ✓Not associated with other eating disorder, medical condition, medication.
- ✓Not related to changes in the individual's sleep-wake cycle or by local social norms.

Source – DSM V

Avoidant and restrictive food intake disorder (ARFID)

Eating or feeding disturbance associated with one or more of the following:

1. Significant weight loss (or failure to gain weight or faltering growth in children);
2. Significant nutritional deficiency;
3. Dependence on enteral feeding;
4. Marked interference with psychosocial functioning.

The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

No body image concerns.

Not attributable to a concurrent medical condition or mental health disorder.

Source – DSM V

Biopsychosocial risk factors of eating disorder

Genetics

Familial aggregation
Twin-based heritability estimates and genome-wide association studies

Social/Interpersonal

Cultural pressures that glorify "thinness" or muscularity and place value on obtaining the "perfect body"
Normalcy of "dieting culture"
Weight Stigma
Life transition
Bullying

Psychological:

History of trauma
Abuse Low self-esteem
Feelings of inadequacy or loneliness
Depression, anxiety, obsessional traits in childhood.
Perfectionism

Weight bias and stigma

Weight stigmatization exists within healthcare system

Health care providers and medical trainees self-report high levels of bias against patients with obesity

Implicit and explicit weight biases were held by 75% of faculty and 66% of medical students respectively.

Obesity in children is associated with cardiometabolic and mental health comorbidities, reduced health related quality of life

Braddock A, Browne NT, Houser M, Blair G, Williams DR. Weight stigma and bias: A guide for pediatric clinicians. Obes Pillars. 2023 Mar 20;6:100058.

Social Media and eating disorders

Social media usage influence body image concerns, disordered eating through social comparison, thin/fit idealization, self objectification

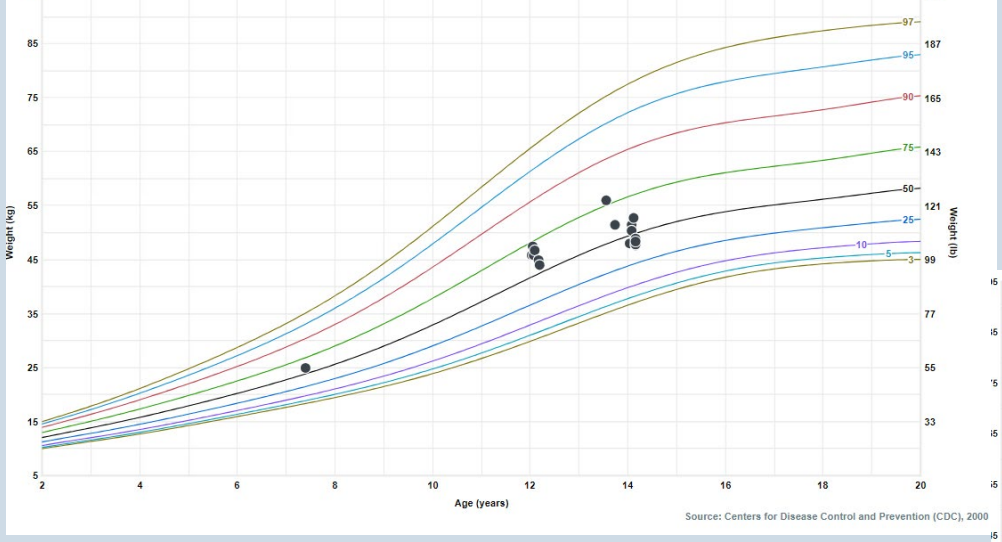
Female gender, high BMI and pre existing body image concerns are risk factors

Social media literacy and body appreciation are protective factors

The social media diet: A scoping review to investigate the association between social media, body image and eating disorders amongst young people

Adolescent's Dilemma

Important to be sensitive, use non- stigmatizing language and demonstrate supportive attitudes toward children and adolescents of all body shapes and sizes. Focus on health behaviors, improving self esteem function & quality of life markers, mitigate health risks rather than just focusing on weight loss


Weight (kg)
Weight (lb)
Age (years)
97
95
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25
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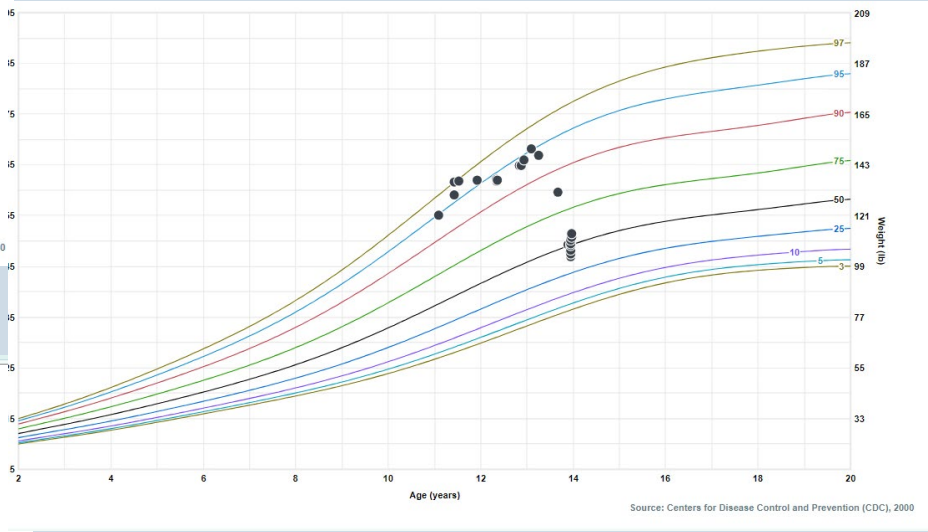
Source: Centers for Disease Control and Prevention (CDC), 2000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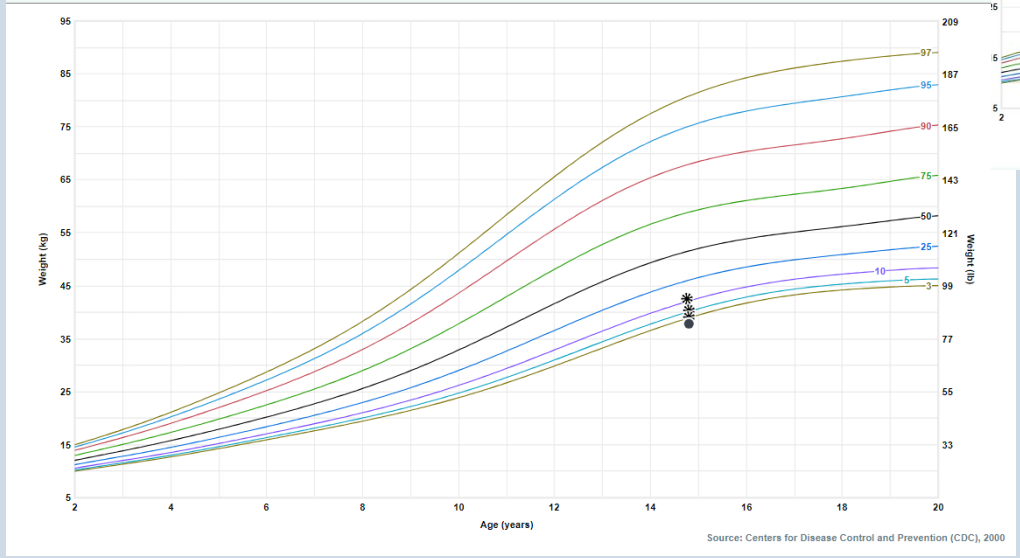
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Source: Centers for Disease Control and Prevention (CDC), 2000

Medical Complications

Complication due to weight loss, vomiting, laxative abuse

Fluids and electrolytes

- Dehydration; electrolyte abnormalities: hypokalemia, hyponatremia, metabolic alkalosis(vomiting), hyperchloremic metabolic acidosis (laxative use)

Psychiatric

- Depressed mood or mood dysregulation; obsessive-compulsive symptoms; anxiety

Neurologic

- Cerebral cortical atrophy; cognitive deficits; seizures

Cardiac

- **Bradycardia** Decreased cardiac muscle mass, right axis deviation, low cardiac voltage; cardiac dysrhythmias, cardiac conduction delays; mitral valve prolapse; pericardial effusion; congestive heart failure; edema

Gastrointestinal

- Delayed gastric emptying, slowed gastrointestinal motility, constipation; superior mesenteric artery syndrome; pancreatitis; elevated transaminases; hypercholesterolemia, Gastroesophageal reflux, esophagitis; Mallory-Weiss tears; esophageal or gastric rupture, laxative dependence

Endocrinologic

- Growth retardation; hypogonadotropic hypogonadism: amenorrhea, testicular atrophy, decreased libido; sick euthyroid syndrome; hypoglycemia/hyperglycemia, impaired glucose tolerance; hypercholesterolemia; decreased BMD

Hematologic

- Leukopenia, anemia, thrombocytopenia, elevated ferritin; depressed erythrocyte sedimentation rate

Casiero et al. Cardiovascular complications of eating disorders card in review 2006;14:227-231

Re- feeding Syndrome

Pericardial effusion
Congestive Heart failure
Hypotension
Arrhythmia
Pulmonary Edema
Muscle weakness
Respiratory compromise
Delirium, Somnolence, Coma
Seizures, Encephalopathy

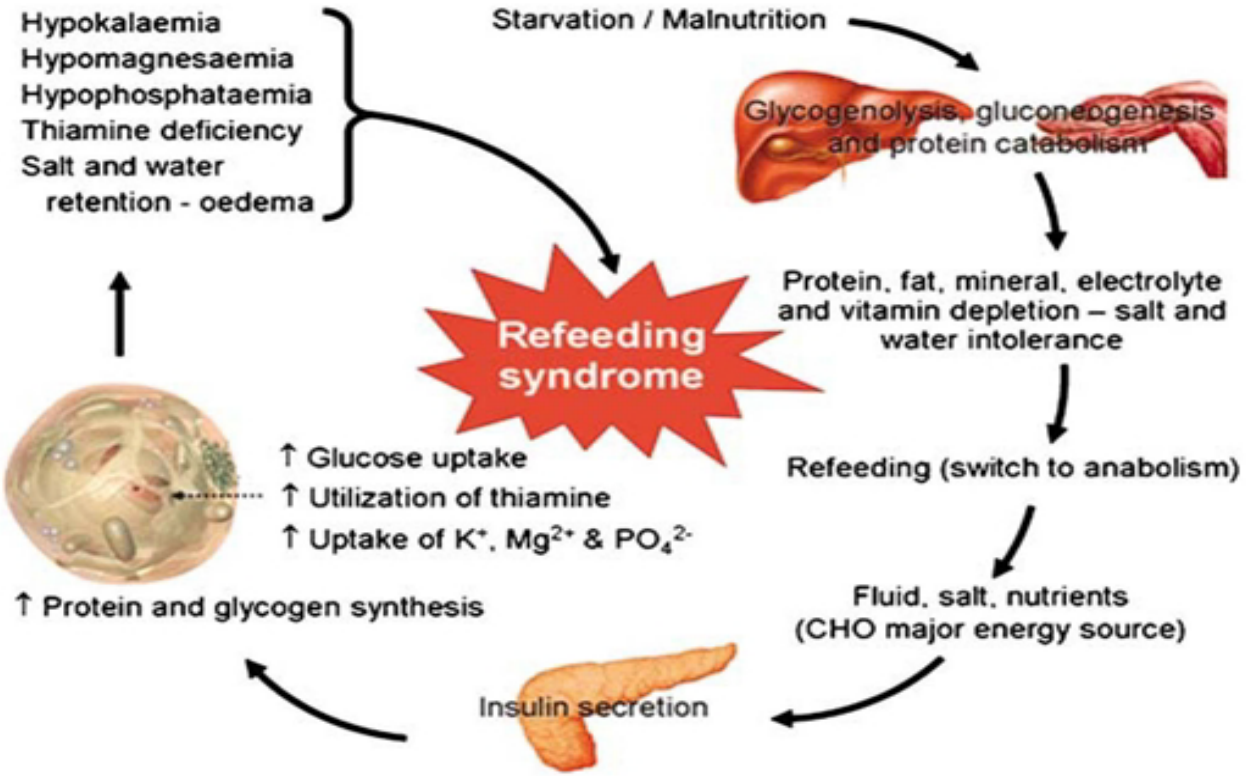


Figure 1 Pathogenesis and features of the refeeding syndrome.

Stanga, Z et al Nutrition in clinical practice—the refeeding syndrome: illustrative cases and guidelines for prevention and treatment; European Journal of Clinical Nutrition, Jun2008, Vol. 62 Issue 6, p687-694, 8p, 1 Diagram, 3 Charts Diagram; found on p688

Bone health

Osteopenia and Osteoporosis is common and a severe complication.

Affects both males and females

Increased risk for stress fractures.

Result from low T3, low estradiol, low testosterone, low IGF-1, high cortisol

High risk in younger patients-1/3 of peak bone density occurs in adolescence.

Low BMD and risk of fracture may persist in adulthood even after recovery.

Endocrine effects of anorexia nervosa. Miller KK. Endocrinology and Metabolism Clinics North Am. 2013 Sep;42(3):515-28. doi: 10.1016/j.ecl.2013.05.007.

Anorexia and Periods

Loss of periods after regular periods established is common

Cessation of menses affects bone mineral density

Resumption of menses:

May occur 3 -6 months after weight restoration

Continued weight gain may be needed if no menses or after menses resumes

Percentage of body fat associated with resumption of menses

No role of OCP unless needed for contraception

Treatment Goal Weight in Adolescents with Anorexia Nervosa: Use of BMI Percentiles Golden,N et al International Journal of Eating Disorders 41:4 301–306 2008 301

Percentage Body Fat by Dual-Energy X-Ray Absorptiometry Is Associated With Menstrual Recovery in Adolescents With Anorexia Nervosa, Pitts, S etal Journal of Adolescent health 2014 Mar 5. pii: S1054-139X(14)00004-4. doi: 10.1016

*NCHS
CDC

Anorexia and Bone health

Nutrition is key !

Weight gain and resumption of menses help to increase BMD

Oral estrogen and progestin have no significant effect

Start patients on calcium (1,300 mg/day of elemental calcium) and vitamin D (600 IU units/day) for maintenance

Dual-energy X-ray absorptiometry scans should be obtained when amenorrhea is present for 6 months or more

Transdermal estrogen (100µg estradiol)+ 2.5 mg of medroxyprogesterone on days 1-10 each month showed improvement of Spine and hip BMD Z-scores

Bi-phosphonates currently not recommended

Endocrine manifestations of eating disorders, Warren, MP J Clin Endocrinol Metab. 2011 Feb;96(2):333-43. doi: 10.1210/jc.2009-2304; Misra M,KatzmanD,Miller K.Ket al 2011

When to suspect eating disorder

Suspect eating disorder

Precipitous weight changes (significant weight lost or gained)

Sudden changes in eating behaviors (new vegetarianism/veganism, gluten-free, lactose-free, elimination of certain foods or food groups, eating only "healthy" foods, uncontrolled binge eating)

Sudden changes in exercise patterns, excessive or compulsive exercise or involvement in extreme physical training

Body image disturbance, the desire to lose weight despite low or normative weight, or extreme dieting behavior regardless of weight

Abdominal complaints in the context of weight loss behaviors

Electrolyte abnormalities without an identified medical cause (especially hypokalemia, hypochloremia, or elevated bicarbonate)

Hypoglycemia

Bradycardia

Amenorrhea or menstrual irregularities

Type 1 diabetes mellitus with poor glucose control or recurrent diabetic ketoacidosis (DKA) with or without weight loss

Use of compensatory behaviors (i.e., self-induced vomiting, laxative abuse, dieting, fasting or excessive exercise) to influence weight after eating or binge eating

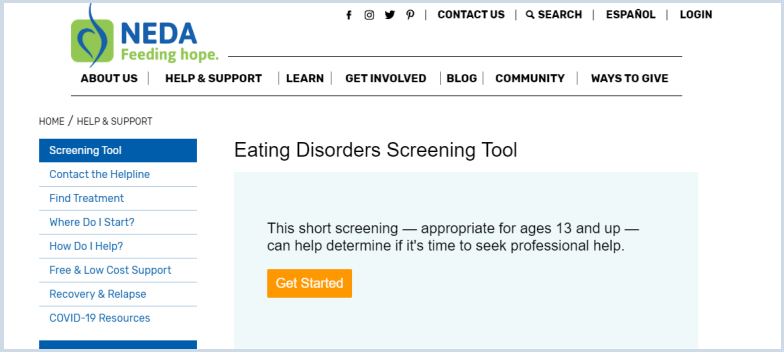
Inappropriate use of appetite suppressants, caffeine, diuretics, laxatives, enemas, artificial sweeteners, sugar-free gum, prescription medications that affect weight (insulin, thyroid medications, psychostimulants or street drugs) or nutritional supplements marketed for weight loss

Lack of interest in food; Avoiding foods due to texture or consistency; being a "picky" eater; refusing to try new foods, requiring food to be prepared a specific way, Feeling afraid to eat due to fear of a possible allergic reactions, choking or vomiting

Screening tool

Online, self-reported questionnaire created by the National Eating Disorders Association with approximately 20 questions, taking <5 minutes to complete. Upon completion, the site indicates level of risk and offers next steps.

Age 13 and older



Adapted from Stanford-Washington University Eating Disorder Screen supported by grant funding from the National Institute of Mental Health (R01 MH081125 and R01 MH100455).

Assessment

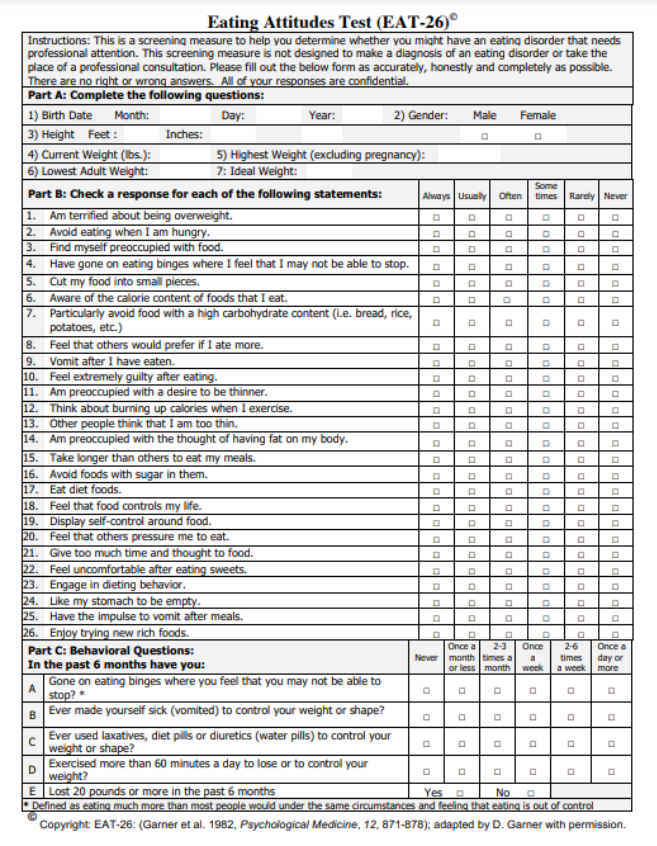
EAT 26

26 self-reported questions using a 6-point Likert scale to assess risk of disordered eating based on behaviors and thoughts.

13 and older

Score ≥ 20 is positive

Eating disorder screen for primary care



Eating Attitudes Test (EAT-26)©

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no right or wrong answers. All of your responses are confidential.

Part A: Complete the following questions:

1) Birth Date Month: Day: Year: 2) Gender: Male ☐ Female ☐

3) Height Feet : Inches:

4) Current Weight (lbs.): 5) Highest Weight (excluding pregnancy):

6) Lowest Adult Weight: 7: Ideal Weight:

Part B: Check a response for each of the following statements:	Always	Usually	Often	Some times	Rarely	Never
1. Am terrified about being overweight.	☐	☐	☐	☐	☐	☐
2. Avoid eating when I am hungry.	☐	☐	☐	☐	☐	☐
3. Find myself preoccupied with food.	☐	☐	☐	☐	☐	☐
4. Have gone on eating binges where I feel that I may not be able to stop.	☐	☐	☐	☐	☐	☐
5. Cut my food into small pieces.	☐	☐	☐	☐	☐	☐
6. Aware of the calorie content of foods that I eat.	☐	☐	☐	☐	☐	☐
7. Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	☐	☐	☐	☐	☐	☐
8. Feel that others would prefer if I ate more.	☐	☐	☐	☐	☐	☐
9. Vomit after I have eaten.	☐	☐	☐	☐	☐	☐
10. Feel extremely guilty after eating.	☐	☐	☐	☐	☐	☐
11. Am preoccupied with a desire to be thinner.	☐	☐	☐	☐	☐	☐
12. Think about burning up calories when I exercise.	☐	☐	☐	☐	☐	☐
13. Other people think that I am too thin.	☐	☐	☐	☐	☐	☐
14. Am preoccupied with the thought of having fat on my body.	☐	☐	☐	☐	☐	☐
15. Take longer than others to eat my meals.	☐	☐	☐	☐	☐	☐
16. Avoid foods with sugar in them.	☐	☐	☐	☐	☐	☐
17. Eat diet foods.	☐	☐	☐	☐	☐	☐
18. Feel that food controls my life.	☐	☐	☐	☐	☐	☐
19. Display self-control around food.	☐	☐	☐	☐	☐	☐
20. Feel that others pressure me to eat.	☐	☐	☐	☐	☐	☐
21. Give too much time and thought to food.	☐	☐	☐	☐	☐	☐
22. Feel uncomfortable after eating sweets.	☐	☐	☐	☐	☐	☐
23. Engage in dieting behavior.	☐	☐	☐	☐	☐	☐
24. Like my stomach to be empty.	☐	☐	☐	☐	☐	☐
25. Have the impulse to vomit after meals.	☐	☐	☐	☐	☐	☐
26. Enjoy trying new rich foods.	☐	☐	☐	☐	☐	☐

Part C: Behavioral Questions: In the past 6 months have you:		Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
A	Gone on eating binges where you feel that you may not be able to stop? *	☐	☐	☐	☐	☐	☐
B	Ever made yourself sick (vomited) to control your weight or shape?	☐	☐	☐	☐	☐	☐
C	Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	☐	☐	☐	☐	☐	☐
D	Exercised more than 60 minutes a day to lose or to control your weight?	☐	☐	☐	☐	☐	☐
E	Lost 20 pounds or more in the past 6 months	Yes ☐		No ☐			

* Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control

Medical Management

Severity of disease

Degree of Malnutrition
- Weight loss/weight suppression

Nutritional intake

Physical complications of malnutrition

Frequency of symptoms (restriction, binge eating, purging, excessive, compulsive exercise, use of laxatives, diet pills, stimulants etc.)

Presence of medical co-morbidities such as diabetes, celiac etc.

Presence of psychiatric co-morbidities such as OCD, mood disorder, substance use

Risk factors- Self harm, homicidal, impaired quality of life due symptoms and complication of malnutrition

Presence of insight, motivation to recover, engagement in treatment

Recovery environment and level of support

https://redcconsortium.org/standards/

Degree of Malnutrition

Term	Abbreviation	Data required and/or Calculation	
Body Mass Index	BMI	Weight (kg) / [height (m)]^2	
Median BMI	mBMI	50 Percentile BMI for age and sex	
Percent mBMI	%mBMI	(Current BMI / mBMI) x 100	
DoM	**Mild**	**Moderate**	**Severe**
%mBMI	80 – 90%	70 – 79%	< 70%
BMI z score	-1 to -1.9	-2 to -2.9	-3 or Greater
Magnitude of Wt. Loss[1]	5%	7.5%	10%
Rapidity of Wt. Loss[1]		5% in 1 month 7.5% in 3 months 10% in 6 months 20% in 1 year	> 5% in 1 month > 7.5% in 3 months > 10% in 6 months > 20% in 1 year

[1]Society for Adolescent Health and Medicine. Medical Management of Restrictive Eating Disorders in Adolescents and Young Adults. J Adolesc Health. 2022 Nov;71(5):648-654. doi: 10.1016/j.jadohealth.2022.08.006. Epub 2022 Sep 2. PMID: 36058805.

Risk factors for refeeding syndrome

The degree of malnutrition at presentation:

<75% median BMI in adolescents,

BMI <15kg/m2 at highest risk in adults,

Patients with rapid or profound weight loss, including those who present at any weight after rapid weight loss (>10-15% of total body mass in (3 – 6 months)

Patients who are chronically undernourished

Had little or no energy intake for more than 10 days

History of refeeding syndrome

Patients with significant alcohol intake (these patients are also at risk for the development of Wernicke's encephalopathy with refeeding.

Prior to refeeding they should receive thiamine and folate supplementation

Post-bariatric surgery patients with significant weight loss (increased risk with electrolyte losses from malabsorption) as well as higher risk of Wernicke's encephalopathy — should also receive thiamine

Patients with a history of diuretic, laxative or insulin misuse

Patients with abnormal electrolytes prior to refeeding

Labs

CBC

CMP

Pre-albumin

Mg, Phosphorus

TSH

Estrogen

Testosterone

EKG

Increased BUN/Cr
Elevated Liver enzymes
Hypo-magnesemia
Hypophosphatemia
Elevated amylase
Metabolic alkalosis, Hypochloremia and hypokalemia : Self induced vomiting
Metabolic Acidosis : Laxative abuse

Management

Includes:-

I. Medical and nutritional intervention
II. Psychological intervention
III. Pharmacologic intervention

Treatment occurs at different levels

NEDA

Immediate treatment goals

Medical stabilization and nutritional rehabilitation to restore weight and address nutrient deficiencies, management of refeeding and its potential complications, cessation of purging, excessive exercise, and compensatory behaviors

Early weight restoration and nutritional rehabilitation, along with treatment at the appropriate level of care, is essential for facilitating recovery.

Levels of care

Inpatient hospitalization	Partial Hospitalization	Intensive Outpatient	Outpatient	Residential
Medical Stabilization and nutritional rehabilitation Monitor for medical stability, refeeding syndrome Start nutritional rehabilitation to achieve calorie goal- NG tube can help with nutritional rehab in non compliant patients with severe eating behaviors and low BMI Psychiatric Stabilization-Suicidality	Full day out patient care Medically stable, and not a threat to themselves or others Some motivation; cooperative; patient preoccupied with intrusive, repetitive thoughts >3 hours/day Needs some structure to gain weight. Others able to provide at least limited support and structure Partial hospitalization programs last between 3 and 12 hours per day, depending on the patient's needs.	Medically stable Fair motivation Adequate emotional and practical support and structure Can manage eating behaviors with support Mild-moderate malnutrition	Medically stable Fair-good motivation Adequate emotional and practical support and structure Self sufficient Can manage eating behaviors Mild malnutrition	Medically stable (intravenous fluids, nasogastric tube feedings, or multiple daily tests are not needed) Poor-to-fair motivation Preoccupied with intrusive repetitive thoughts 4–6 hours a day Patient cooperative with highly structured treatment Needs supervision at all meals

Practice guideline for treatment of patients with Eating Disorder, 3rd edition APA
National eating disorder association

Criteria Supportive of Hospitalization for Acute Medical Stabilization	Criteria for Hospitalization for Acute Psychiatric Stabilization
Presence of one or more of the following	**Presence of one or more of the following**
1. ≤ 75% median BMI for age, sex, and height, or prolonged severe caloric restriction causing significant weight loss in the absence of underweight 2. Hypoglycemia 3. Electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia and/or metabolic acidosis or alkalosis) 4. ECG abnormalities (e.g., prolonged QTc>450msec, bradycardia, other arrhythmias) 5. Hemodynamic instability • Bradycardia • Orthostatic hypotension • Hypothermia 6. Acute medical complications of malnutrition (e.g., syncope, seizures, cardiac failure, pancreatitis, etc.) 7. Acute severe food refusal unresponsive to outpatient treatment 8. Comorbid psychiatric or medical condition that prohibits or limits appropriate outpatient treatment (e.g., severe depression, suicidal ideation, obsessive compulsive disorder, type 1 diabetes mellitus) 9. Uncertainty of the diagnosis of an ED	1. Suicidal thoughts or behaviors 2. Aggression or unsafe behaviors 3. Other significant psychiatric comorbidity that interferes with ED treatment (anxiety, depression, obsessive compulsive disorder, mood instability)
Other Considerations Regarding Hospitalization	
1. Inability to address symptoms at a lower level of care. 2. Binge eating and/or purging behaviors unable to be controlled in outpatient setting or lower level of care 3. Inadequate social support and/or follow up medical or psychiatric care	

Academy of eating disorder- Medical guidelines

ANOREXIA NERVOSA: WEIGHT RESTORATION

Typical ranges of **weekly weight gain** vary with the treatment setting.

Suggested rate of weight gain by level of care	Pounds per week
Outpatient	1 to 2
Intensive outpatient	1 to 2
Partial hospital	1 to 3
Residential	2 to 4
Inpatient	2 to 4

- Higher level of care is usually needed if no progress after 6 weeks of treatment (e.g., average weight gain of 0.5-1 lb/week in patients with AN).

- Generally, the closer to patient's target weight before discharge, the less risk of relapse and readmission; also, less risk of relapse likely if patients maintain weight for a period of time before being discharged from inpatient or residential treatment.

Management in outpatient settings while awaiting placement in eating disorder treatment

Monitor vitals, electrolytes – Orthostatic vitals, weigh checks, labs – CMP, mag, phos- 1-2 weeks

Education for parents and caregivers

- Explain role of proper nutrition- “Food is medicine”
- Dangers of severe malnutrition; critical importance of prioritizing weight restoration early in the treatment of restrictive eating disorders.
- Nourishment is essential; healing cannot occur until the patient is adequately fed. Nutrition is as vital as antibiotics for severe infections or chemotherapy for cancer.
- The longer a child remains malnourished, the more challenging it becomes to treat the eating disorder.
- Patient with higher body weight still need ongoing nourishment and may gain weight as they nourish themselves. Keeping the weight same while being restrictive prolongs the malnourished state.

Evidence based treatment

Family based therapy : Maud slay Method

Evidence based and effective in teens

3 phases :

a) **Weight restoration: Assist Parents in re-feeding**

focus on the physical dangers of severe malnutrition from ED and assist the parents in re-feeding the adolescent and restoring weight

b)**Returning control over eating to the adolescent**

encourage the parents to help their child to take more control over eating again, and focus on return of the adolescent to physical health

c) **Establishing healthy adolescent identity**

starts when adolescent is able to maintain weight, and includes supporting increased personal autonomy for the adolescent and development of appropriate parental boundaries

Eating Plan

Herrin Food Plan

Breakfast: calcium, complex carbohydrate, fruit or vegetable, protein (optional), fat (optional)

Snack

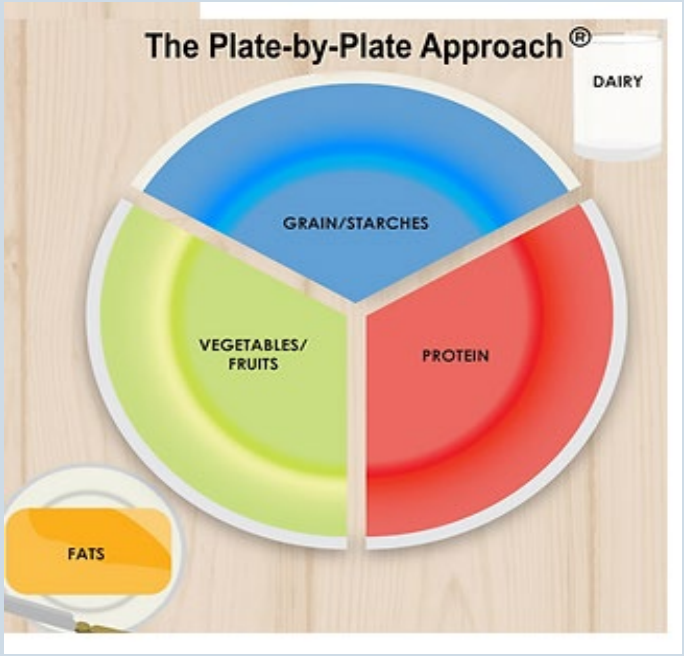
Lunch: calcium, complex carbohydrate, fruit or vegetable, protein, fat, "fun food"

Snack

Dinner: calcium, complex carbohydrate, fruit or vegetable, protein, fat, "fun food"

Snack

Gradually increase intake
Eat 3 meals and up to 3 snacks every day
Eat at least every 3 hours
Eat at least 3 food groups per meal



Source: Herrin, Marcia, and Maria Larkin. Nutrition Counseling in the Treatment of Eating Disorders. 2nd ed. New York: Brunner-Routledge, 2003.

Medication

Limited role for treatment of Anorexia

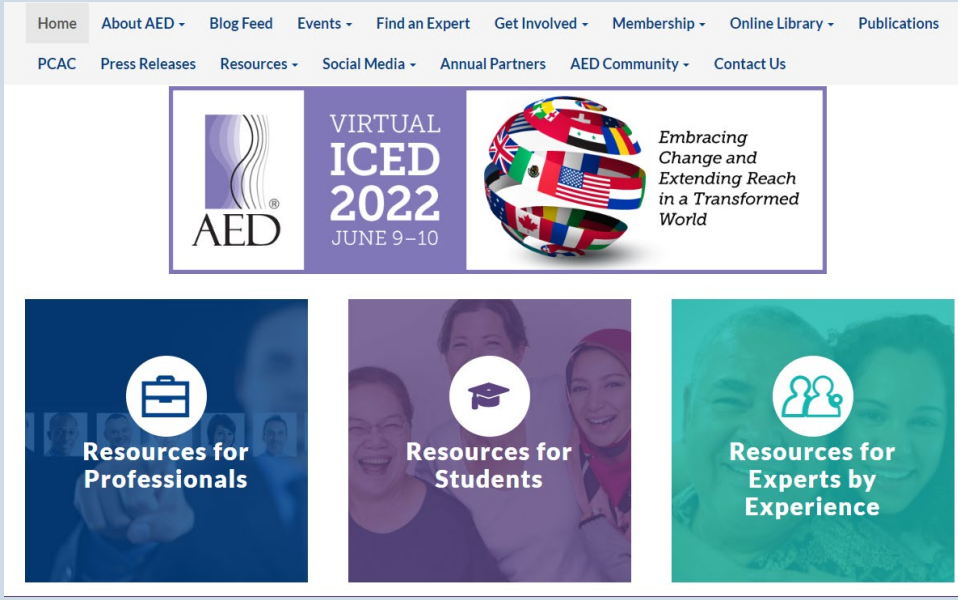
Used for treating co existing conditions such as anxiety, depression

May help with purging behaviors in Bulimia

Binge eating – Vyvanse, Topamax

Resources


CALL HELPLINE | CHAT NOW | SCREENING TOOL | SHOP | DONATE
CONTACT US | SEARCH | ESPAÑOL | LOGIN
NEDA
Feeding hope.
ABOUT US | HELP & SUPPORT | LEARN | GET INVOLVED | BLOG | COMMUNITY | WAYS TO GIVE
LEARN
What are Eating Disorders?
Warning Signs and Symptoms
Identity & Eating Disorders
Body Image
Prevention
Statistics & Research on Eating Disorders
Treatment
NEDA Brochures
Professional Development
CONTACT THE HELPLINE
You can call our confidential eating disorders Helpline
EATING DISORDERS
What are Eating Disorders?
Eating disorders are serious but treatable mental illnesses that can affect people of every age, sex, gender, race, ethnicity, and socioeconomic group. No one knows exactly what causes eating disorders, but a growing consensus suggests that a range of biological, psychological, and sociocultural factors come together to spark an eating disorder.
Read more >
Warning Signs and Symptoms
The chance for recovery increases the earlier an eating disorder is detected. Therefore, it is important to be aware of some of the warning signs of an eating disorder.
Read more >
Identity & Eating Disorders
Misconceptions about who eating disorders affect have real consequences, leading to fewer diagnoses, treatment options, and pathways to help for those who don't fit the stereotype. Understanding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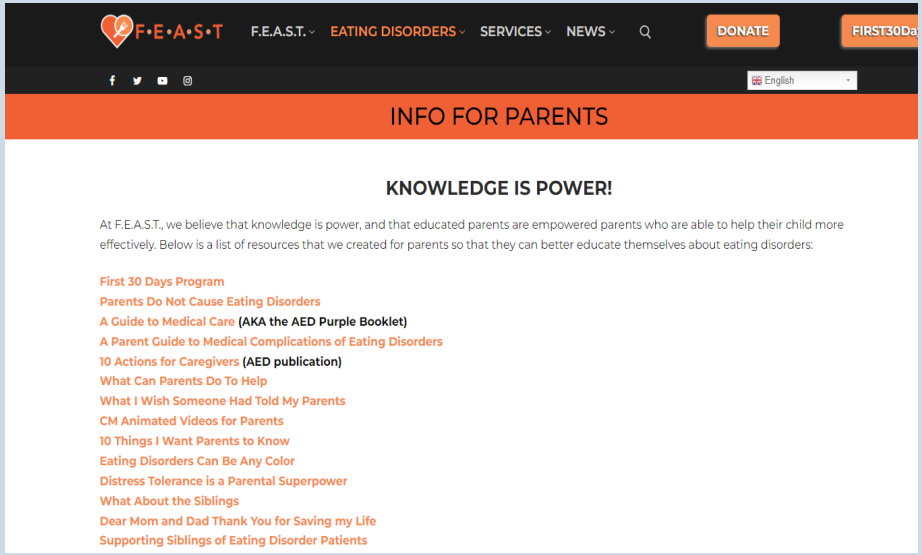
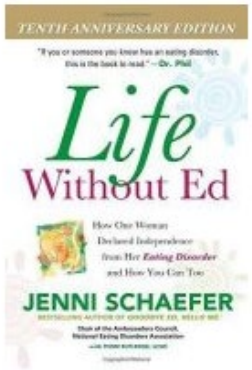
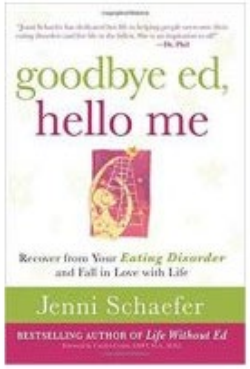
JUNE 9–10
Embracing Change and Extending Reach in a Transformed World
Resources for Professionals
Resources for Students
Resources for Experts by Experience


F·E·A·S·T
F.E.A.S.T. | EATING DISORDERS | SERVICES | NEWS | DONATE
English
INFO FOR PARENTS
KNOWLEDGE IS POWER!
At F.E.A.S.T., we believe that knowledge is power, and that educated parents are empowered parents who are able to help their child more effectively. Below is a list of resources that we created for parents so that they can better educate themselves about eating disorders:
First 30 Days Program
Parents Do Not Cause Eating Disorders
A Guide to Medical Care (AKA the AED Purple Booklet)
A Parent Guide to Medical Complications of Eating Disorders
10 Actions for Caregivers (AED publication)
What Can Parents Do To Help
What I Wish Someone Had Told My Parents
CM Animated Videos for Parents
10 Things I Want Parents to Know
Eating Disorders Can Be Any Color
Distress Tolerance is a Parental Superpower
What About the Siblings
Dear Mom and Dad Thank You for Saving my Life
Supporting Siblings of Eating Disorder Patients



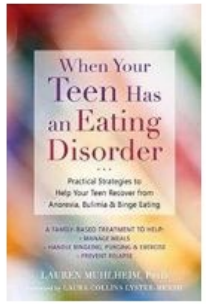
Life Without Ed

By Jenni Schaefer



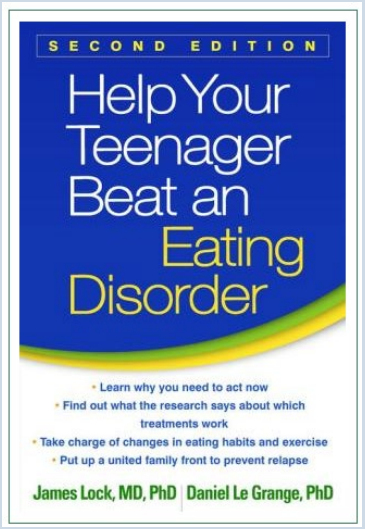
Goodbye Ed, Hello Me

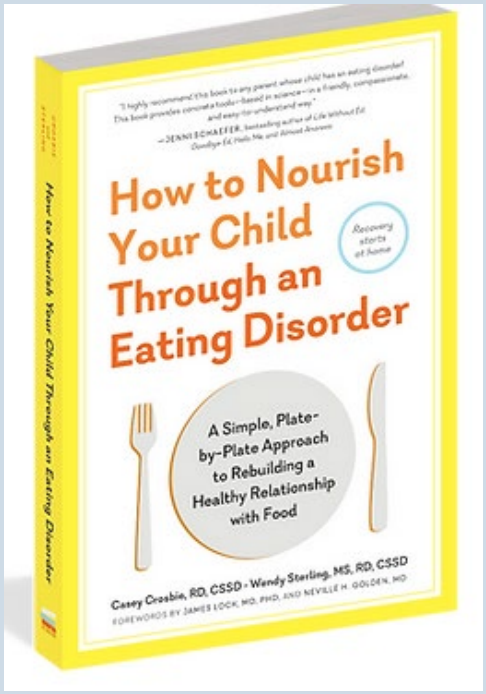
By Jenni Schaefer

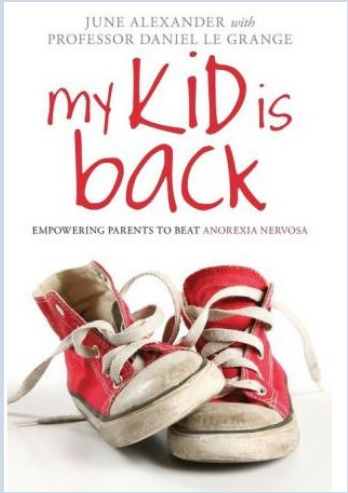


When Your Teen Has an Eating Disorder: Practical Strategies to Help Your Teen Recover from Anorexia, Bulimia, and Binge Eating

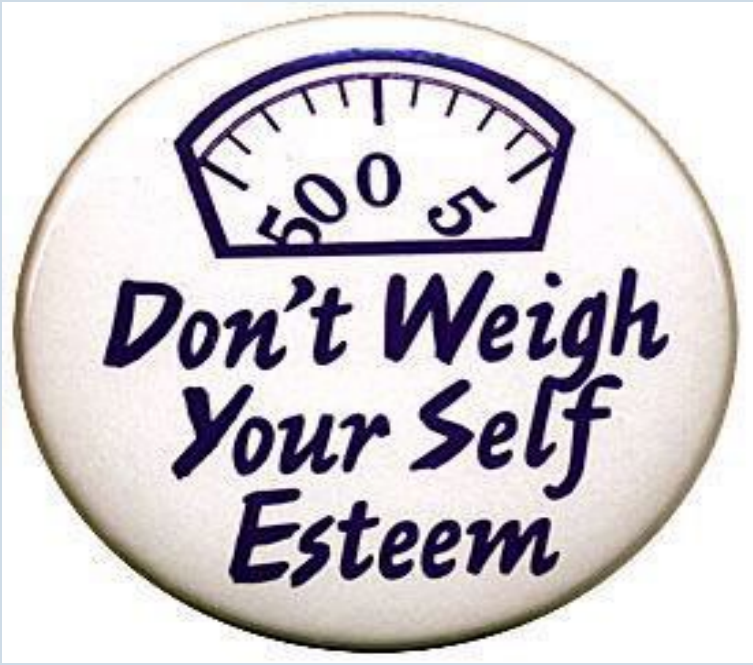
By Lauren Muhlheim, PsyD







Thank you



QUESTIONS ?