Assessing Growth in Children and Adolescents for the Screening, Treatment and Prevention of Eating Disorders Webinar

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la-shell_johnson@med.unc.edu: Good afternoon and welcome to everyone who is online with us right now. We would like to welcome you to the webinar titled, “Assessing Growth in Children and Adolescents for the Screening, Treatment, and Prevention of Eating Disorders” presented by Ms. Anna Lutz.

la-shell_johnson@med.unc.edu: A few things to note, participants will be muted upon entry and videos will be turned off. If you need any technical assistance, we ask that you use the chat box function. The last 10 minutes of the webinar will be designated to address any questions for the presenter. We would like for you to place your questions in the Q&A section in order to ensure that we can address those questions. In approximately three months, you will receive an email requesting feedback on the impact of today's webinar and, lastly, we would encourage you to visit the NCEED training Center at www.nceedus.org/training to view other webinars and training opportunities.

la-shell_johnson@med.unc.edu: At this time, I would like to introduce today's presenter, Ms. Anna Lutz, who specializes in eating disorders and pediatric and family nutrition. She is a certified eating disorders registered dietitian and approved supervisor, both through the International Association of Eating Disorder Professionals and has previously worked at children's national medical Center in Washington, DC where she served as an outpatient registered dietitian at the Delaney Eating Disorders Clinic. She is also a national speaker and delivers workshops and presentations on eating disorders, weight inclusive healthcare, and childhood feeding. Anna also serves on the board at the Carolina Resource Center for eating disorders. She currently writes about nutrition and family feeding free of diet culture at Sunny Side Up Nutrition and has worked in private practice since 2006. I will now turn things over to Ms. Anna Lutz.

Anna Lutz: Great, thank you Courtney so much. I'm thrilled to be here today and to be talking about a topic that's important and near and dear to my heart. So today, we are going to be talking about growth in children and adolescents. Courtney did a great job introducing me. I have a private practice in Raleigh, North Carolina where I see individuals with eating disorders and supervise other dieticians, and these topics that we're going to be talking about today come up over and over again, so I'm thrilled to be talking to other professionals about these topics.

Anna Lutz: So our objectives. There's three sections that I'm going to go through today, one is screening, so the importance of assessing growth charts when we're screening individuals specifically children and adolescents for eating disorders. Then the second part is going to be talking about treatment or

establishing an expected body weight—how to use growth charts to establish if someone has an eating disorder, how we think about and discuss weight, and then thirdly we're going to talk about prevention and your practice. Thinking about how to approach all clients from a weight inclusive perspective to in the hopes of preventing eating disorders.

Anna Lutz: So what we know is that eating disorder rates are on the rise. You can see here that this study that came out in 2019 showed a doubling of worldwide eating disorder rates. You know which of course is quite concerning and now in during the COVID-19 pandemic; we are seeing more and more information about rates increasing. I know personally just the need for our services has you know, gone up so much and so we're in a situation where I need to be on the lookout and know that if we're seeing clients or patients, most likely we're seeing someone with an eating disorder.

Anna Lutz: Specifically, with adolescents, you can see the prevalence rates. You can see that binge eating disorder has the largest prevalence. When they expanded the diagnostic the criteria from the diagnostic criteria for anorexia nervosa and bulimia nervosa and expanded that to behaviors that suggest you can see how the numbers increase and that the mean age onset of eating disorders is 12 and a half.

Anna Lutz: And something that I think is really important to note is that eating disorders affect everyone. All races, ages, socioeconomic background, all genders, all body types and sizes, and all sexual orientations, it affects everyone. What we also know is that there are many barriers to care, not everyone has equal access to eating disorder treatment, and so you know one way I see that we can be working on that is for us all to be educated about eating disorders. And for us to work on our own bias about who has an eating disorder and know that it affects everyone.

Anna Lutz: A lot of what I'm going to be talking to today is backed up in this brand new paper from the American Academy of Pediatrics that came out just this past January, less than two months ago. So I wanted to point people to this paper, if you haven't seen it already, particularly the pediatricians that are here. This is a great paper that lays out the identification management of eating disorders in children and adolescents. And another important thing to note is that eating disorders are defined by behaviors. They are not defined by weight, and so you know we are going to be talking about growth and weight a lot today but, remember that eating disorders is not just a behavior. None of us knows or can look at someone and know if they have an eating disorder, or not. We cannot weigh someone and know if they have an eating disorder or not.

Anna Lutz: Weight and weight trends can be clues, but they are not the diagnostic criteria. So we're going to talk a bit about screening.

Anna Lutz: So when thinking about the primary care providers' role and eating disorder screening, they're well positioned, because on an annual basis they're weighing and measuring the children and adolescents that come and see them at their annual visit. So they can follow these trends over time. That is a really important piece, but it's also really important to ask about eating and body image concerns.

Anna Lutz: Has there been a change in eating, a change in exercise? What else is going on in their life, major life stressors? Has there been mood changes? What else is going on? And then, after this kind of full assessment, deciding if a referral is needed or not.

Anna Lutz: So these are our blank growth charts pulled from the CDC website. The boy's is on the left, 2 to 20 year old growth chart and the 2 to 20 year old girl's growth chart is on the right. The blue lines represent when the time um on average, when the rate of height increase is at its highest. So the growth spurt for each of these growth charts, so when the child is growing, the quickest.

Anna Lutz: And what we know you know this this you know correlates with puberty and what we know is when a child's height is increasing greatly their weight is also increasing greatly. The red line on the girls' growth chart is the average time of menarche, which is about 12.6 years. And so there's a lot of changes that has to happen before a girl has their first period. The reason I am pointing this out is that we know that in this age group there is so many changes happening. On average, children are gaining at least 10 pounds a year on average to stay on their growth curve and this can be, you know alarming to parents, it can be alarming to the child who may not understand puberty. If taken out of context in the healthcare system we all work in, it can be alarming if someone says, "Oh, my goodness, I've gained 15 pounds this year." If we see it through you know, a more weight focus perspective and we have our own weight bias, that might be alarming. So really thinking about that, children's bodies are supposed to change and they change dramatically as they are supposed to.

Anna Lutz: Just to kind of talk more about this, and this is specifically for the female body composition changes during puberty. You know that fat mass increases again so that periods can start. It's significant, you can see that the change in body fat is 120% during puberty for girls.

Anna Lutz: And in four years on average, a girl will gain 40 pounds. So again, it is just as interesting and important to kind of highlight these changes that are happening and need to be happening, and it's very healthy to happen as a child goes through puberty.

Anna Lutz: This data is from NHANES and this time girls are on the right, we have boys on the left. We have girls and it's a change in body fat percentage over time and it's interesting to me, and something honestly that I learned is that you can see the girls curves of growing from age 5 to age 19.

Anna Lutz: Body fat percentage increased more smoothly, I would say quite a bit more smoothly than the boys. The boys had a more drastic increase that then fell and then started to increase. Again, just interesting information about how bodies change.

Anna Lutz: So we're going to talk a bit more about growth curves and we're talking about screening. So this is an example of a child that is tracked high tracking weight for age there, you can see that.

Anna Lutz: Their stature for age chart is on the left. This person is quite tall compared to their peers they're tracking above the 95th percentile height for age. On the right, we see someone who is tracking above the 95th percentile weight for age on the right.

Anna Lutz: If this tracking their height percentile was lower, let's say their height percentile is closer to 50th percentile or lower and the height of the weight percentile looked like this, that would be fine too—it would be fine to say this child is growing very predictably.

Anna Lutz: You know genetics plays a big role in our body size and shape. I want to point out, I know this is really different than how many doctors and dietitians are trained traditionally. But, what we know is you know when we talk to children who are tracking predictably, there's not a concern with their behaviors in general they're tracking and growing as their body intended.

Anna Lutz: So opposite of that, this is an example of a child that's low tracking weight for age. Okay, and so you know I didn't specifically go into this at the last slide. But the bottom of the growth chart is age, so we've got two go over to age 20.

Anna Lutz: This particular growth chart combines weight and height, so the bottom one is weight going up the y-axis, where we have weight.

Anna Lutz: They have also put the height chart on there, so starting above the weight you can see different heights.

Anna Lutz: And so, each time the child goes to the pediatrician they're weighed and measured and a point is put on here. So you can see here this child is growing between the 25th and 50th percentile height for age. And for weight they're growing on this, on the lower end they're smaller. They weigh less compared to their peers kind of hanging on to that bottom between the 10th and the fifth percentile.

Anna Lutz: So this is what we would call negative dysregulation. This gets into the things that are a bit more concerning those first two examples. You become concerned about either one of those children by just looking at their height and weight not asking them any questions, just looking at their height and weight.

Anna Lutz: This is concerning as you can see, at age 12 between 12 and 13, this is the height. Excuse me, this is the weight curve this child was tracking right along the 75th percentile, and then there was a drastic drop.

Anna Lutz: This would, um need great attention. What is going on? Why has this child lost weight? They've crossed percentile lines and then kind of looking over at the height curve, you can kind of see there hasn't been a big change. This last little bit they're starting to fall off their hype curve probably from malnutrition, to make some assumption, but this is something that we would be concerned about what's going on.

Anna Lutz: There are lots of possible causes to negative dysregulation and it can be as drastic as that example, or it could just be a slowing of weight gain that where the child is not staying on their own growth curve, their own specific growth and so they might still be gaining weight, but they're, they're growing. Excuse me they're gaining weight slower, it could be an indication of eating disorder. It could also be you know appetite-suppressing medication, we see that quite a bit.

Anna Lutz: There could be something going on with other things that interfere with a child's intake that's not an eating disorder—sensory processing disorder, and this example, maybe there's something going on endocrine wise, of course, we want to rule that out.

Anna Lutz: Something that we're going to be looking at today is the possibility, and that would not be from the example I just showed, but late onset puberty will also make a child look like they're falling off their growth curve if they are developing later. They’re hitting their growth spurt later, everything is going to be shifted over in the growth curve.

Anna Lutz: So you know they might still be gaining weight and gaining height, but it's not at the rate that the average population is and again that's what's, that's what's tough is the growth charts are about averages. Huge population data is used for these growth charts, but we're really only now you know when you have a client or patient in front of you you're only thinking about what's going on with this patient, so we need to figure out what might be going on.

Anna Lutz: Has there been a significant change in activity level? Is there anything else going on autoimmune wise, GI wise? And so really kind of assessing that. So the opposite of that negative dysregulation would be acceleration and weight for age. So you see this is an example here, where the child was growing along the 95th percentile and started to veer off of the curve, that they had kind of established for a while. Their height jumped up a little bit in the percentile between that second point, which is a little bit after three, age three and that third point, which is a little after four jumped up a bit and then kind of you know, it's finding its curve it didn't change a whole lot. And so, I look at that as was there a big change in their way to their height go way off their growth curve. Does that explain where there might have been a change in their percentile of their weight for age?

Anna Lutz: So what might cause that? It could be natural growth that doesn't follow population averages. And I think we need to remember that the growth charts are helpful, but not every child follows the exact pattern that these averages have mapped out. There could be something going on emotionally, psychologically, that could be affecting their intake.

Anna Lutz: You know I wonder if there was their history of restrictive feeding in the past, and, as the child grows older, they have more autonomy with their eating and that restrictive feeding might have led to more the child, making sure they're going to get enough food.

Anna Lutz: Is there early onset puberty? So the opposite of the above, that we were just talking about. If a child goes through puberty early, then things are going to be shifted the other way and so oftentimes we'll see the height go off the growth curve early and the weight and there might be early puberty that kind of veers back to their original growth pattern as the years go on.

Anna Lutz: Is there a restrictive eating disorder that is leading to restrictive and restricting binge cycle? what might be going on endocrine wise? has there been new medication? has there been a change in activity level, either increase or decrease?

Anna Lutz: What else is going on? But, but, what we do know is regardless of the cause that we try to control someone's weight, what we know from the research is that leads to weight acceleration and weight cycling. Meaning you know, encouraging diet, dieting, losing weight, and gaining weight. There's so many health consequences associated with that weight cycling.

Anna Lutz: So, again we're talking about the screening. So when we're using growth charts we want to make sure we're looking at this patients growth chart, not comparing them to others. And that's an important piece that I often explain to parents is that we're not comparing your child to others. Let's look at what they've, how they've been growing since they were two, what's been going on and has their weight for age crossed percentile lines?

Anna Lutz: If they're plotting along whatever percentile it is, 95th percentile, 100th percentile, fifth percentile. They've been plotting along there, that's not something I'm concerned about. But if they have accelerated weight gain wherever that is veering off their growth chart curve, let's be curious about it, or if they have decelerated weight gain let's be curious about it; and that deceleration could be slowed weight gain like we talked about. It could be no weight gain.

Anna Lutz: And you know, children are supposed to always be gaining weight. There could be weight loss and let's be curious and figure out what's going on. Let's check to see if, if, if, the height explains what might be going on with the weight. Let's assess for puberty. Where are they in puberty? Is there early puberty, late puberty, and then ask those important follow up questions.

Anna Lutz: So I get asked a lot, "So what do I do with a BMI growth curve?" And you see, you can see that I haven't put up a lot of the BMI, I don't think I put up any at this point BMI growth curve.

Anna Lutz: What we know is the way the BMI is very small changes in height and weight, make huge changes on the BMI growth curve, so it's quite volatile.

Anna Lutz: BMI in general is not helpful for individuals. It wasn't designed to treat individuals. And so I personally really think we gather a lot more clinical information by focusing on height for age and weight for age. Now, if a height has drastically crossed percentile lines up or down, sometimes it's helpful for me when I'm trying to determine expected body weight with someone who needs to weight restore, and we're going to talk about that in the next section, I might look at the BMI chart to help me kind of gauge.

Anna Lutz: Because if someone was trotting along on the 50th percentile height for age and all of a sudden now they're at the 98th percentile height for age, so they've really jumped up. You know their weight for age percentile needs to be higher, because they're there now taller, and so I might be kind of using that as a clue.

Anna Lutz: Also, the way that BMI is if someone is taller than their peers their higher on the height for age growth chart they're more likely for that BMI to be higher, and so, sometimes it's not the most helpful indication.

Anna Lutz: Another thing to note is Z scores. So the the space that's above the growth charts is uncalibrated, so above some growth charts have the top percentile is the 95th others the top percentile

line, excuse me, as the 97th. Opposite is true, below some the lowest percentile, and his fifth or the lowest is third once you get all above or below those percentile lines.

Anna Lutz: The space on the growth charts are not calibrated so you can't look at percentile changes by just looking at it. You need to be using Z scores to see if they're moving further from the mean, and I use just a simple Z score calculator that you can use to kind of assess where they are.

Anna Lutz: So here's a quick example that I wanted to show you. We are going to call this client Jane, and you can see that Jane, between age seven and that's the earliest information I had, was kind of plodding along on a pretty consistent growth curve and veered up a bit at age nine and kind of jumped up to the next percentile line at age nine. Then between 11 and 12 and a half, there was slowing and kind of veered back to that original line, and then there was a lot of weight deceleration.

Anna Lutz: An eating disorder was diagnosed here around 14. There was some weight gain, but not back, full weight restoration was not achieved, and there was some continued weight loss. So this is her height for age and what you can see, is right along between age 10 and age 12 and a half, her height really jumped up and percentile lines and what's of note, is that if you look back at the weight between 10 and 12 and a half, there was that kind of deceleration.

Anna Lutz: That, that would be concerning because the height was really you know, increasing but we saw a little bit of that mimicking of the weight increasing, and I think that's why she jumped up between age nine and 11 and 11 and a half, but then that deceleration was a clue that something might be going on.

Anna Lutz: And just to look at, I wanted to kind of show you the kind of more drastic changes, you see, on a BMI chart. So, this would be something that this, this, negative deceleration that at 12 and a half, would it be important to kind of wonder what's going on. I think it might be an example of someone maybe praising a child for slowed weight gain kind of, “Oh good you're getting back to that line,” but I think it’s also you know really digging in there, asking questions would have been a clue that an eating disorder was starting.

Anna Lutz: So we really want to remember that weight and height are only clues, right they're defined a lot of times is vital signs. They're only clues, and so we want to use them to help guide our questioning, but then we really want to ask about dieting behaviors, body dissatisfaction, experience of weight stigma, have they been bullied, or have they been told. I have a lot of clients that you know might have gone to a pediatricians checkup and we're told that their percentile is too low or too high, they needed to lose weight, and then they've really been restricting after that visit. And so we want to ask about what's going on, has there been changing in eating habits. We know from the research that people with

eating disorders do report that more than people who don't have eating disorders, that they have a history of being a vegetarian. That doesn't mean people that are vegetarian have eating disorders.

Anna Lutz: But if you know, it's a clue to listen out, for, if you have a teenager that has this decided to be a vegetarian and their family is not. Has there been changes and exercise habits?

Anna Lutz: What else is going on in their life doing an assessment for abuse trauma, and is there amenorrhea? And that paper from the American Pediatric Academy that I showed at the beginning and the extensive more thorough questions are there, that you can pull.

Anna Lutz: So I don't love the name of this, but this is atypical anorexia, is the term that is used right now in the medical field to describe someone who meets all the criteria for anorexia nervosa, but except the criteria that says they need to be significantly underweight.

Anna Lutz: And so, but what we know from research is that people who have atypical anorexia meaning they're greatly not eating enough, their body image, they have great body image disturbance. All of the medical complications are the same regardless of what someone's weight is and so that any weight loss in children really needs to be evaluated with concern, no matter what the pre morbid weight was.

Anna Lutz: And, and another thing I think is really interesting is this research from Dr. Lowe about weight suppression. So weight suppression is defined by someone's current weight, and this study was done with people with eating disorders presenting for treatment.

Anna Lutz: They compared it to their highest weight, so you know what their current weight was compared to their highest weight.

Anna Lutz: And what we know, what they found in the studies is the bigger that differences, the more severe the eating disorder behaviors and the less improvement in treatment of their symptomatology.

Anna Lutz: Regardless of what their weight was currently, it’s that difference in the highest weight compared to the current weight was a really significant predictor of how they were doing in treatment and how they were doing at presentation. This graphic I think, is a great graphic to kind of illustrate that so you can kind of see the cookie, the little gingerbread people on the right, the yellow ones they're all the same weight, but the bigger the difference is between the green and the yellow ones, that's kind of he's predicting the first one is a low weight suppression moderate and high and just how important that is to progress and eating disorder treatment and current symptomatology.

Anna Lutz: So we all want to be listening I think that's an important kind of take home today is.

Anna Lutz: You know, will hear clients or parents say you know, “You know he’s just thinned out, that's what all his siblings did too.” You know, if you’re looking at a growth curve and someone has fallen off their career growth curve.

Anna Lutz: Well, that very well, might be true, but that probably doesn't mean that the siblings fell off their growth curve, you could look at it and assess it.

Anna Lutz: You know, ‘ I've never weighed this much in my life’ and I like to say to adolescents, “You're right and that's how it's supposed to be. As an adolescent you're always growing, growing, and gaining, and your weights are going to continue to increase that's what needs to happen”, or ‘I've gained 10 to 15 pounds over last, last, year.’” Yes that's normal, so what happens during puberty; let's take a look at a growth curve.” You know if there is concern about periods, people talking about exercise and we just, we know that.

Anna Lutz: You know from the research about exercise and periods, how important it is for an athlete to eat enough to sustain their periods to protect their bones. If you hear things about you know totally cut out any kind of junk food, have made all these changes, or kind of focusing on trying to make a change in these areas. When I wrote these, these were things I was thinking that adolescents and teens would say.

Anna Lutz: Alright, so we're going to keep moving into treatment, so the eating disorder treatment team at a minimum, usually includes a medical provider, a psychotherapist, and a registered dietitian.

Anna Lutz: And today we're focusing a bit more on the PCP role on the eating disorder team. So they're assessing and monitoring medical stability, along with your dietitian especially is one term they may use for expected body weight. They might give clearance for exercise for medical management and emphasize health and vitality.

Anna Lutz: So what is a healthy weight? And that's probably something I’m hoping will be something that you leave this webinar thinking about. What is really a healthy weight? You know we can look at charts and we're taught that there are certain cut offs. But you know when I think about what a healthy weight, I think about someone eating well, listening to their hunger and fullness, moving their body in a way that feels good, and having the energy they, they need. Not thinking about food too much. You

know when we don't eat enough, we think about food a whole lot. But I think we need to start thinking about this term, “healthy weight” in a completely different way.

Anna Lutz: So, there's traditionally or and even some continues now in eating disorder treatment, there's this difference in these terms of ideal body weight, which is strictly looking at an adolescent or child’s at their current age, what is the 50th percentile weight for age or BMI for age, and saying that that's the ideal body weight. A more nuanced way to for treatment is to really look at someone's historical weight.

Anna Lutz: Where they are in puberty, their menstrual history, assessing their intake. Really doing a full assessment and coming up with what we would call an expected body weight, that's very unique to this patient and that is really what’s shown to help with long term relapse prevention.

Anna Lutz: So when we're determining an expected body weight, we want to assess the historical growth trajectory, looking at those growth curves, I’m asking myself, ’has the height cross percentile lines if it has, then, then it would be expected the weight for age would also cross,’ so we need to take that into account.

Anna Lutz: We need to always be projecting six months out. So if I’m figuring out a patient’s expected body weight now, I am looking at what they would need to be six months out on their growth curve. So if they're 12 now, at 12 and a half what would they need to be, to be back on their growth curve, if weight restoration is needed.

Anna Lutz: I really encourage providers to think of it as a minimum, maybe a range, but a lot of times if there's a range then we're saying you know it could be interpreted as you don't want to go up above a certain weight. So a minimum is a nice way to think about it, and you know for health and vitality, I think we need to be above this minimum and that we need to be reassessing children and adolescents every three to six months. It's a moving target by the time we get to that first expected body weight it's been six months, so we need to move it and stay ahead of the ball. So going back to Jane, if you kind of remember, you know if we're looking back at where she presented which was at age 14 and a half. Then we look at the height curve that also crossed percentile lines and stayed up at that high percentile, then we really want to get her back to, to that new curve that she was starting to plot when her height jumped up and that what we know is that probably is going to really reduce her risk of relapse. It's going to support recovery, that's what I want to talk about a little bit. Because we have this evidence that shows that as little as five pounds can make all the difference in someone starting to have regular periods again, it can be just that, that, little, little, difference and that unexpected body weight may need to be set. There's some research that shows two kilograms above where we might think it is, to start the menstrual cycle back again.

Anna Lutz: And so, so knowing that we don't want to be setting expected body weights too low. This is something I come up against a lot. I'll be really honest with you, with my clients, but also the other adolescents that we see in my practice is the parents and other providers being pretty concerned, wanting expected body weights, to be set lower, saying that you know, they don't want their child to be quote overweight. They felt so uncomfortable before their eating disorder, and they don't want them to feel uncomfortable again.

Anna Lutz: And so you know really thinking about the health risks of having a sustained eating disorder, for a long time.

Anna Lutz: You know and not kind of, and this is talked a lot in that paper I've been mentioning throughout, is that really not having parents, but really kind of you use that to influence how we set expected body weight. That that, that, fear that I think is really influenced by our culture, diet culture, and how we think about bodies. If that starts to dictate how we treat people with eating disorders, we're really stuck in a cycle, there were the diet culture is playing a role in the development of eating disorders, but also the treatment of eating disorders.

Anna Lutz: We know that full weight restoration supports recovery as little as 2.2 kilograms has been shown to drastically reduce a person's risk of relapse and I love the metaphor that Carrie Arnold talks about in her book, *Decoding Anorexia*. If you're trying to get up a hill if you're right at the top of the hill, but you're not all the way at the top it's really easy to slide back down. But once you get over that hump and you're at the top of the hill, you can kind of look around and play around up there. What we find is that if we stop treatment too early, when the client is on this side of the hill it is so easy for them to slide back down, and so we really need to be looking at full rate weight restoration.

Anna Lutz: So what if we don't have historical growth curves. You know this is like, I always get excited honestly when I can, when I can, get my hands on historical growth records, I can really look at a growth curve. I can really assess it but that is not the case a lot of times. So we might defer determining expected body weight for later and just say well we're going to.

Anna Lutz: You know let's try to get above this minimum, or let's just see how this goes and let's focus on these other things. Again I'm talking a lot about weight today. But there's plenty of people with eating disorders, who do not need to weight restore and I would say, actually, most of the people who have diagnose eating disorders weight restoration is not a piece of their treatment and so that we need to be focusing on normalizing eating patterns.

Anna Lutz: You know, and looking at their signs of health and usually these things fall into place when someone is at the body weight that their body wants to be.

Anna Lutz: So true signs of health, you know these are just some examples and I, this is a list I love to make with my clients, when we talk about weight and they might be concerned about um, where they're expected body weight might be, or where their body might end up at the end of treatment. And we might together just make a list of what, what is true health. How is how, how is health really defined you know, that we're told that it's defined by weight, but, truly there's so much more than that.

Anna Lutz: Okay, so we've talked a bit about screening, we've talked a bit about using growth charts in the treatment of eating disorders and that was mostly for individuals that needed to weight restore, and now we're going to move into prevention. So thinking about in your own practice how you might practice with all individuals through a weight inclusive lens as to you know, be a part of the prevention of eating disorders, I think, are trained, including myself, to treat people with eating disorders in one way and treat people without eating disorders in another way. And so, I love the way Jessica Setnick who is a registered dietitian, talks about this. She talks about universal precautions for eating disorders. So just like when we take people's blood, we use universal precautions, we put on gloves right we don't we don't wait and figure out if someone has a blood borne illness before we put on the gloves.

Anna Lutz: So just the same way we don't want to wait and see if someone has an eating disorder or see if someone's going to develop an eating disorder before we treat them from a weight inclusive lens. If we treat everyone that way, we focus on healthy behaviors and not weight, then we're preventing eating disorders.

Anna Lutz: So I have here risk factors of eating disorders, this is pulled right from the, from the National Eating Disorder Association's website. And I've highlighted things that I think as medical providers that we could play a role in, or maybe the best way to think about is that we could not play a role in. That we cannot encourage dieting or negative energy balance, that we can work on decreasing weight stigma in our offices, that we cannot play a role in body dissatisfaction of our clients. There's a lot on this list that we, we might not that might not be controllable will say you know, or if we think about from individuals perspective, but there are some things in the treatment of eating disorders are the risk factors that we can we do play a role in, and we can kind of think about that.

Anna Lutz: So what we know from the research is that long term dieting doesn't work. We know that dieting behaviors and children and adolescents is associated with increased BMI and binge eating and both girls and boys. So if work, you know is the reason that someone is dieting to decrease their weight or their body mass index, you know long term, we see that, that doesn't work, and we also see that it increases eating disorder behaviors binge eating.

Anna Lutz: In this study, 14 to 15 year olds dieting behaviors were the strongest predictor of eating disorders at three year follow up; so that's pretty significant. In three-year follow up, the strongest prediction of eating disorders was dieting behavior and that weight talk is associated with both increased risk of eating disorders and high BMI, so weight talk being weight talk in the home. The study specifically weight talk in the home among parents, you know, focusing on weight, people needing to be to lose weight, even if it wasn't directed towards the child.

Anna Lutz: There was this increased risk of eating disorders and increased BMI. And what we know about feeding practices is children that have restricted access to highly palatable food have increased intake of those foods. And so this is, this is a study that people in my field quote a whole lot. Which is they took children, and it was actually girls, and they, they, divided them into two groups: one that had access to snack food at their homes and one that did not and individually, they put them in a room with a bunch of food, a bunch of snack food and they assessed how much they ate. And this was an absence of hunger and the children that did not have those foods at their home, did not have access to those foods, ate quite a bit more of the snack foods or highly palatable foods.

Anna Lutz: We know that maternal restrictive feeding practices predict daughters eating in the absence of hunger and so that restrictive feeding doesn't help, you know, eating competence, children listening to hunger and fullness and increase BMI and that parents attitudes about overweight, you know, how they talk about people's weight is predicted of restrictive feeding practices. And you know you'll notice through this talk, I haven't been using terms like overweight or obesity, just because I think they are pathologizing terms that evoke weight stigma. But studies use these terms, so I do use those terms when they're using the studies. And so what we know is that you know just the way parents think about weight, really predicts how they feed their children and that restrictive feeding isn't helpful in the long run. So this is another piece if we're working with kids and adolescents, how we talked to the parents about weight.

Anna Lutz: So weight stigma mentioned wasting a couple times, weight stigma is discrimination against or stereotyping others based on weight. What we know is that weight stigma comes from all parts of our culture, including healthcare professionals and that experiencing weight stigma leads to depression, anxiety, poor body image, social isolation, unhealthy eating behaviors, and increased BMI.

Anna Lutz: And so again, even if, if we think you know discriminating against someone because of their weight is going to quote help with their weight, the research isn't there that, that happens. It actually causes quite a bit of harm.

Anna Lutz: So what we know there is in 2016 the American Academy of Pediatrics came out with a paper and it's in the resources here, and it was a focus on health. What they said was let's focus on healthy behaviors rather than weight.

Anna Lutz: And this was a paper that was written about that there is so much overlap between children that are diagnosed with quote unquote obesity and children that are diagnosed with eating disorders and the risks are very similar.

Anna Lutz: And so, when we're practicing let's focus on healthy behaviors and not be talking to children about weight.

Anna Lutz: So what to kind of continue on that, is to just remember that weight is a clue. What weight is doing as a clue if a weight, if a weight veers way off above that acceleration?

Anna Lutz: Yes, we should respond to it, we should really be wondering what's going on. What, what, might be going on in the home? What might be going on eating wise that might have caused that? Let's just be curious, what are the behaviors or experiences that might be going on?

Anna Lutz: I really encourage, I think growth curves, and weight is complex and confusing even for adults and talking about it directly to children can be really confusing and scary.

Anna Lutz: I never want a child to hear that there's something wrong with their, their body and that something drastic needs to happen. And so, if there is a concern if it's possible the way your practice is set up to talk to parents, without the child present and then refer them to someone for further assessment and support, but let's really focus on those behaviors.

Anna Lutz: You know that's another kind of big take item that weight is not a behavior, but it might be a clue into other things that might be going on and we want to screen for trauma, food insecurity, teasing, bullying. What else might be going on, that this weight change on their growth curve might be telling us something and there might be nothing going on, and I do want to say that too. There might be nothing going on.

Anna Lutz: So we want to encourage health promoting behaviors. There's so much research about activity, family meals, eating regular meals and snacks, getting adequate sleep, that all these things support health.

Anna Lutz: And if we change our dialogue and our offices to focus on these behaviors that these support health, and don't cause the harm that we know that focusing on dieting and restricting does.

Anna Lutz: Positive body image is not a, it's not a behavior, but I wanted to just put that out there that we know that positive body image supports health, feeling good about our body.

Anna Lutz: There's really interesting research that shows that the more someone has good feelings about themselves in their body, the more likely they are to engage in these health promoting behaviors. And so as health professionals, we don't want to be the ones that are leading to negative body image and causing that body dissatisfaction. And we want to really be discouraging behaviors that don't promote health, discouraging dieting and skipping meals, discouraging weight talk, discouraging prolonged screen time.

Anna Lutz: And I wanted to highlight that this, this, quote is interesting to me which, which, says that "longitudinal data of adolescent females suggests that, even though body weight percentiles track throughout adolescence, little consistency guides the intakes of the energy, nutrients, vitamins, and minerals from early to late adolescence."

Anna Lutz: So, even though, how a child tracks on their growth curve is, is pretty consistent and predictable, their intake, what they're eating, is not, it's very volatile and so as health professionals, we want to refrain from jumping to conclusions about the dietary habits of adolescence.

Anna Lutz: Even if they have been evaluated in the past, take time to assess their current intake before jumping to conclusions.

Anna Lutz: Alright, so we're getting to the end here, so, in conclusion, we really want to think about what way can be one clue in the development of an eating disorder, but it by no means is the whole story. Someone can have an eating disorder without their weight changing at all.

Anna Lutz: But, but we want to be on the lookout, especially in the primary care setting and we're assessing growth charts on an annual basis.

Anna Lutz: Let's be curious behind the dysregulation, it could be a sign of disordered eating, it could not, let's just be curious.

Anna Lutz: We, we know that full weight restoration and nutritional rehabilitation decreases rates of eating disorder relapse so we don't want to set the eating the expected body weight too low, so that we want to support full recovery. We want to focus on behaviors not weight, and so it might be something.

Anna Lutz: Tangible to think about is when you're you might be trained to talk about weight and do an intervention regarding weight, how can you turn that around to focus on a behavior and really take the weight out of it.

Anna Lutz: Do not talk with/to children about their bodies being wrong, I think that's a big one, and that really comes from both the research. But it also comes from you know I've treated eating disorders, for almost 20 years now, and so many stories are about children being told by a healthcare provider, or a parent that their body was too big and that was a big part of their development of an eating disorder. And so you know, I think, as we all want to practice from a do no harm perspective, thinking about how we talk to children and following the American Academy of Pediatric guidelines of not talking to children about weight, and to remember that genetics has a big influence on body size and shape. And that weight gain is very normal and expected throughout childhood and is really higher rate in the teen years.

Anna Lutz: And so here are the references. And then I'm happy to answer questions Thank you so much.

la-shell_johnson@med.unc.edu: Great, thank you Anna. We will now begin our question and answer segment and as a reminder, we do ask that you use the Q and A box so that we make sure we can address your question.

la-shell_johnson@med.unc.edu: If we have any questions that we do not get to answer because we run out of time, I will make sure to send those to Anna and she will provide responses and I will email those out to everyone.

la-shell_johnson@med.unc.edu: As a quick reminder following today's webinar, you will receive an email with a link to the evaluation form, as well as a copy of the slides from today's presentation.

la-shell_johnson@med.unc.edu: If you know, anyone who would be interested in viewing today's presentation, we will have this available on-demand in our training Center in about two weeks or so. So the first question is, do you have any recommendations or experiences, you can share regarding the assessment and treatment of ARFID and the key differences from other eating disorders?

Anna Lutz: That's such a great question. I think that's it's important for us all to be trained on treating ARFID, because we're seeing that more and more. I think, because it's a fairly new diagnosis.

Anna Lutz: I really love the resources from Katja Rowell. I'm gonna spell her last name -- R O W E L L, and her work with responsive feeding. You know, I think that's a great idea for maybe a future webinar is to really focus in on ARFID.

Anna Lutz: Courtenay remind me what the first part was, was it about resources?

la-shell_johnson@med.unc.edu: It was if you had any recommendations or experiences you can share regarding treatment.

Anna Lutz: Okay.

Anna Lutz: So I do work with quite a few people with ARFID and so do the dietitians in my practice and you know what, what, we know is this eating disorder has been present of course it's not a new eating disorder. The diagnosis was new, it was added to the DSM V in 2015 and prior to that the similar diagnosis. So prior to that the similar diagnosis, so ARFID stands for avoidant restrictive food intake disorder, so extreme picky eating for those who don't know that term ARFID. So the diagnosis, was in the feeding disorder part of the DSM IV and that whole section was eliminated and this new diagnosis of ARFID was put in the eating disorder section and can be diagnosed in any age. And what we see is that it's a pretty big diagnosis that has a lot of different subtypes.

Anna Lutz: And that some, there's certainly an overlap with sensory processing disorder and autism spectrum disorder. Other people might develop ARFID, because they've had an incident, like a choking incident, and might become very scared of food. There's a big association with trauma.

Anna Lutz: And ARFID, so you know we really want to be careful with assessing what's going on and the way we treat people with ARFID may need to be different than the way we treat people with anorexia nervosa and bulimia nervosa. And particularly figuring out what was the cause, since there's so many different presentations and subtypes.

la-shell_johnson@med.unc.edu: Great and part of that too, Anna was um you know differentiating between like someone with assessing sensory difficulties possible autism spectrum disorder or

condition. ADHD or learning disability and involving occupational therapists or other experts in neurodevelopmental conditions.

Anna Lutz: Yes, I think that's a very important piece, anytime we're assessing someone with an eating disorder. And to, to, assess for sensory processing to assess for trauma and when I'm working with an individual with ARFID, I'm really hoping to find an OT on the team that really understands the nervous system and you know how feeding and the nervous system kind of overlap.

la-shell_johnson@med.unc.edu: Great! The next question is, if a child was overweight by 20 kilograms and developed an eating disorder and is now a normal weight for height, do you want them to regain that 20 kilograms or just normal weight gain throughout adolescence?

Anna Lutz: I think that's a you know that's a question that I get asked a lot, and I think it would, I'd have to ask lots of questions and so really what we want is for that client to have that health and vitality, that we talked about. So that they're eating in a way that's not restrictive. That they're thinking about food less, they're moving their body. For some people to do that, they might have to regain to pre morbid weight, some people don't and it's you know metabolism is complicated. But what we don't want is for someone to maintain a restrictive eating disorder in order to keep you know, an artificially low weight for them, and so that it's a lot of work and communication between the dietitian, the family, the, the adolescent of really figuring that out together.

la-shell_johnson@med.unc.edu: Okay um, how do you respond to push back from parents, when you raise concerns about their children's recent weight loss?

Anna Lutz: It's a great question! I when I can, I really like to show them the growth chart when it's available and to explain. I know I'm a visual learner and so that really seems to help parents, when you can show them the growth curve and explain to them what we're seeing on the growth curve. Also, you know really talking to them about any kind of weight loss would be concerning in a child, we need to, we need to assess what might be going on, if there has been weight loss. And, and, really sometimes I'll name, you know we're in a culture that weight loss is praised, it makes sense that you might have different feelings than I do.

Anna Lutz: But what we know is that specifically in children, we really need to respond to this and, and do an assessment and figure out what might be going on. But I do really like, if I have the growth charts to kind of explain that, if I have the time you know in my setting and an outpatient setting a lot of times, I do have the privilege of having that time of sitting down with parents and kind of reviewing growth charts.

la-shell_johnson@med.unc.edu: Okay and I know you provided your references are links to the papers that you mentioned available in your references?

Anna Lutz: I think most of them are there, the links. Okay.

la-shell_johnson@med.unc.edu: And do you have any reference that you can provide for determining expected body weight?

Anna Lutz: I've cited on those slides where expected body weight is discussed in several different papers, including the new paper that came out in January from The American Academy of Pediatrics. You know there's, there's not a consistent consensus. A lot of the consensus is that we need to use historical growth charts. That's the consensus that you'll see that wording throughout all the papers is let's, we need to use historical growth, growth charts.. There are different approaches and you can kind of look in the different, the different papers to kind of see those different approaches. But, but when it comes down to it, what we know is looking at where the child was pre-morbid, before they're eating disorder diagnosis, we need to get them back to where they were for their symptoms to fully subside.

la-shell_johnson@med.unc.edu: Okay, and then also along with that is, in your opinion, how much do you think the RD should or can be involved in determining expected bodyweight?

Anna Lutz: Well, I really think we're well positioned to and should be playing a pretty major role in it. Because, again we have a lot of times, we have the time you know, we're able to meet with clients for longer. We have the you know, we might be spend a lot of the dietitians meeting with individuals with eating disorders are specialized in eating disorder so they've had a lot of advanced training and practice determining expected body weight. So ideally it's, it's a team effort you know. It's a discussion with the pediatrician or the PCP and that you're, you're looking at it together, but you know the expertise that the dietitian, especially the eating disorder dietitian, can bring I think needs to be a pretty significant part of that decision.

la-shell_johnson@med.unc.edu: Okay um How does early onset of puberty factor into determination of the EBW?

Anna Lutz: So great question.

Anna Lutz: So if you, if i'm gonna go back to this blank growth charts to kind of show you if you and, Courtenay said early puberty?

la-shell_johnson@med.unc.edu: Early onset, yes.

Anna Lutz: Early onset, okay, hold on one second. It’s going to get back to these okay so just, I'm just going to go over to the girls, just to pick one or the other, but we know that this red line like I said is that's menarche, average age of monarchy. But let's say someone had their first period at age 11. What their growth charts might look like is that their height and weight for age really cross percentile lines before the two years before 11 that there was a sharp increase, because they were having their growth spurt earlier than on average and then what we often see is that over time.

Anna Lutz: You can see on this blank or growth curve, if you just are looking at the height one. The slope of the line start to come down right around where that blue line starts, you can kind of see the second blue line. The, the slope starts to come down and it levels off, right. Well that's going to happen earlier for someone who has early puberty their slip or their line might start to curve more around 12/13 instead, instead of 14/15 and so same with the weight, you can see, this starts to level off, where it was really sharp. Between the two that starts to level off some, it still goes up but it levels off some and so a lot of times what we see is they'll return to their, their line. Their, their, own weight for age line before their early puberty. They'll, they'll kind of return to that and it'll look like they're crossing back you know. They will be crossing back so you want to take it into account that they might have shot up, but after puberty they're going to veer back if that makes sense.

la-shell_johnson@med.unc.edu: Okay, and it is two o'clock, I just want to be very mindful of everybody's time. I know we did not get to address all questions. I will send these to Anna and then, and I'll email those responses and you know, give us about a week and we will get the rest of these responses out to everyone who attended.

la-shell_johnson@med.unc.edu: Anna, thank you so much for today, and thank you to all who attended.

Anna Lutz: Thank you Courtenay I appreciate everyone for tuning in.

Anna Lutz: Great.

la-shell_johnson@med.unc.edu: bye.