When it is more than anxiety or depression: eating disorders and obsessive-compulsive disorder

by Dr. David Smith

The ages between 12 to 24 are challenging for almost all youth. The biological, social, physical and psychological path to adulthood is not easy, even under the best of circumstances. But coupled with that tough journey is the fact that 75 per cent of all mental health disorders first show up in these teen/young adult years, too. For the majority, the mental health issue is apt to be mild to moderate anxiety or depression; both highly treatable.

A number of other very important mental health issues, however, also tend to arise first in the teen years. Here is some general information and links to resources for two specific issues: eating disorders and obsessive-compulsive disorder. Next week we will talk about bipolar disorder and schizophrenia.

In all cases, if you suspect your child might be suffering from a specific condition talk to your family doctor or contact the Child and Youth Mental Health clinic provided by the Ministry of Children and Family Development in your nearest community. Call Service BC at 1-800-661-8773 to find the nearest MCFD office to you.

Eating disorders: The transition from adolescence to adulthood is particularly risky for the development of anorexia nervosa (AN) and bulimia nervosa (BN). An estimated 0.9% of young women aged 12 to 24 will develop AN, while about 1.5 % of young women develop BN. While young women are three times more likely to develop these disorders, young men in recent years are increasingly showing to have eating issues.

While our societal obsession with thinness may set the scene; genetic risk factors, as well as underlying anxiety, perfectionism and self-esteem issues are thought to combine to trigger the disorders. Once anorexia starts and the body gets into starvation mode, the brain chemistry changes. As well, the body's dehydration, altered electrolyte balance and poor nutritional status can lead to heart rhythm issues and other organ function problems. The goal in treating anorexia is to re-feed the person to a healthier weight, and then treat the disordered thinking behind the condition, with one or more of the most effective treatments. These treatments include cognitive behavioural therapy (CBT), family-based therapy and dialectic behavior therapy (DBT). Re-feeding and psychotherapy may co-occur once the person is progressing to a healthier weight. With bulimia, along with CBT, antidepressant medication has been shown to be helpful. In both conditions, medications may be helpful if there is a co-occurring mood or anxiety disorder, as is often the case.

Symptoms of AN to look for in your teen include rapid or significant weight loss, food restriction and obsession with calories or exercise. For BN, weight loss may not be very apparent, but your teen may go to the washroom immediately after eating and run the water. You may see evidence of vomiting in the toilet bowl.

Since anorexia has the highest mortality rate of any psychiatric illness, it is important to seek help at the first signs. For more information and to see a full listing of provincial programs, including the Provincial Specialized Eating Disorders Program for Children and Adolescents at BC Children's Hospital, as well for videos and other helpful information, see Kelty Eating Disorders, keltyeatingdisorders.ca. Another source for information is the National Eating Disorders Information Centre, nedic.ca.

Obsessive-Compulsive Disorder (OCD): Obsessions are repetitive, intrusive and unwanted thoughts that cause the affected youth great anxiety. Compulsions are the actions or the rituals that he or she must go through to reduce the anxiety caused by the obsessive thoughts.

A very common OCD obsession is about contamination or germs, with the compulsion being the need to hand wash repeatedly or avoid any surface, individual or situation where germs might be present. Another common OCD obsession is the fear that something terrible will happen unless the youth takes a specific ritualistic action, like counting, checking, or placing items in a specific order.

Genetic risk factors plus an environmental trigger are thought to set off the illness, which tends to run in families. One environmental trigger that may be linked to sudden onset OCD symptoms in some susceptible children is a recent infection with *Streptococcus A* bacteria (Strep throat.) This burgeoning, but controversial area of research may yield more insights in future years.

Treatment with antidepressant-types of medication plus exposure response prevention therapy – a specific form of cognitive behavioural therapy that features gradual exposure to the issue causing the obsessive thoughts and compulsions — has been shown to have success with some individuals. Left untreated, however, OCD can be very debilitating. The longer the OCD goes on, the harder it is to treat.

Again, if you are worried about possible signs of OCD in your child, see your family doctor or the Ministry of Children and Family Development CYMH clinic in your region. They may refer your child to specialized services, such as psychiatric services or the specialized OCD program at BC Children's Hospital. For more information, see ocdbc.ca, kelthymentalhealth.ca or the OCD pages at cmha.ca

Next column, we will talk about Bipolar disorder and Schizophrenia. .

Dr. David Smith is an adolescent and adult psychiatrist and the medical director of the Okanagan Psychiatric services for Interior Health. *This series of columns on common child and youth mental health issues is a project of the Child and Youth Mental Health and Substances Use Collaborative. The Collaborative involves multiple individuals, organizations and ministries all working together to increase the number of children, youth, and their families receiving timely access to mental health services and support in the Interior Health and Vancouver Island regions.* *The Collaborative is jointly funded by Doctors of BC and the government of BC.*