Eating Disorders: Diagnoses, Considerations, and Treatment

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Planner Disclosures

The following series planners have no relevant conflicts of interest to disclose:

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Speaker Disclosures

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DEFINITION OF TERMS

Diagnoses according to the DSM 5

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Anorexia Nervosa

- Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health
- Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight
- Subtypes

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Bulimia Nervosa

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
- Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances
- A sense of lack of control over eating during the episode
- Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications; or excessive exercise
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months
- Self-evaluation is unduly influenced by body shape and weight
- The disturbance does not occur exclusively during episodes of anorexia nervosa

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Binge Eating Disorder

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - Eating, in a discrete period of time (e.g., within any 2-hour period), and amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances
  - A sense of lack of control over eating during the episodes
- Marked distress regarding binge eating is present
- The binge eating occurs, on average, at least once a week for 3 months
- 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 or anorexia

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Avoidant Restrictive Food Intake Disorder (ARFID)

- An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
  - Significant weight loss (or failure to achieve expected weight gain or faltering growth in children)
  - Significant nutritional deficiency
  - Dependence on enteral feeding or oral nutritional supplements
  - Marked interference with psychological functioning
- The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice
- The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced
- The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention

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Other Specified Eating Disorder

- This applies to presentations in which symptoms characteristic of a feeling and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the other disorders
  - Atypical Anorexia Nervosa: May not have significant weight loss
  - Bulimia Nervosa (of low frequency and/or limited duration)
  - Binge-eating Disorder (of low frequency and/or limited duration)
  - Purging Disorder: Recurrent purging behavior to influence weight or shape in the absence of binge eating
  - Night Eating Syndrome

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Unspecified Eating Disorder

- This category applies to presentation in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. This may be used in situations in which there is insufficient information to make a more specific diagnosis

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Eating Disorder Prevalence

- Almost 50% of people with eating disorders meet the criteria for depression.
- Only 1 in 10 men and women with eating disorders receive treatment.
  - Only 35% of people that receive treatment for eating disorders get treatment at a specialized facility for eating disorders.
- Up to 30 million people of all ages and genders suffer from an eating disorder (anorexia, bulimia and binge eating disorder) in the U.S.
- Eating disorders have the highest mortality rate of any mental illness.

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A Note on Rapport

It can be difficult to start the conversation, particularly when the patient is in denial about the severity of the illness

Convey genuine empathy and curiosity while avoiding judgement

Check your emotional reaction

We all have preconceived notions about patients with eating disorders

We all have our own relationship with food, weight and our body

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Principles of Collaborative Care

	Patient-Centered Team Care Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals. The ability to get both physical and mental health care at a familiar location is comfortable to patients and reduces duplicate assessments. Increased patient engagement oftentimes results in a better health care experience and improved patient outcomes.

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Principles of Collaborative Care

	Population-Based Care Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.

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Making A Diagnosis

- “Eating disorder” is rarely the chief complaint (unless they are dragged in by a worried family member)
- Instead…
  - Cold Intolerance
  - Polyuria
  - Fatigue
  - Amenorrhea
  - Sore Throat
  - Constipation

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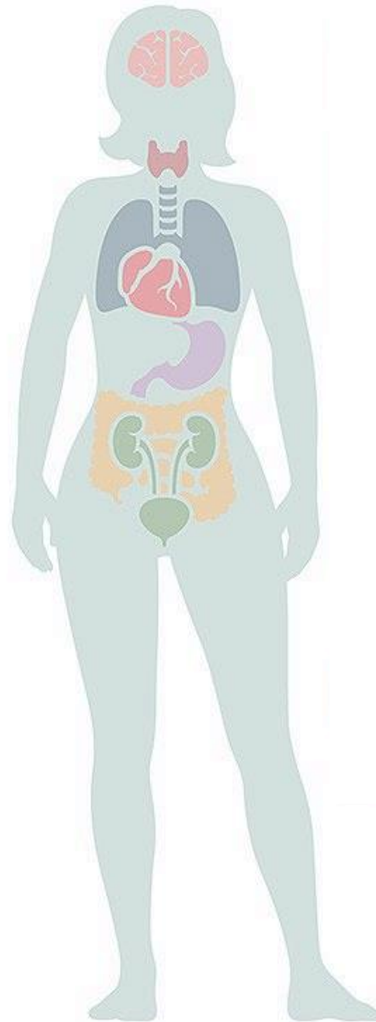
Making A Diagnosis

Anorexia Nervosa

- Usually related to organ dysfunction due to malnutrition and the person being underweight
- Starvation affects all organs of the body



Bulimia Nervosa*

- Usually related to the type of purging used, frequency, and duration

*Of note, patients with AN, binge/purge type, can have these issues as well

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Making A Diagnosis

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Principles of Collaborative Care

	Measurement-Based Treatment to Target Each patient’s treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured by evidence-based tools like the PHQ-9 depression scale. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved. Sometimes called Stepped Care.

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Eating Disorders: Quick Screen

- **Eating Disorder Screen for Primary Care**
  - Are you satisfied with your eating patterns? (*No is abnormal*)
  - Do you ever eat in secret? (*Yes is abnormal*)
  - Does your weight affect the way you feel about yourself? (*Yes is abnormal)*
  - Have any members of your family suffered with an eating disorder? (*Yes is abnormal*)
  - Do you currently suffer with or have you ever suffered in the past with an eating disorder? (*Yes is abnormal*)

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Principles of Collaborative Care

	Evidence-Based Care Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition. These include a variety of evidence-based pyschotherapies proven to work in primary care, such as PST, BA and CBT, and medications. Collaborative care itself has a substantial evidence base for its effectiveness, one of the few integrated care models that does.

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Treatment team

- Patient
- Behavioral Health Care Manager
- Registered Dietitian
- Primary Care Physician
- Psychiatrist

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Role of the Behavioral Health Care Manager

- The behavioral health care manager is responsible for coordinating and supporting mental health care within the clinic and for coordinating referrals to clinically indicated services outside the clinic. The behavioral health care manager may provide evidence-based treatments or work with other mental health providers when such treatment is indicated.

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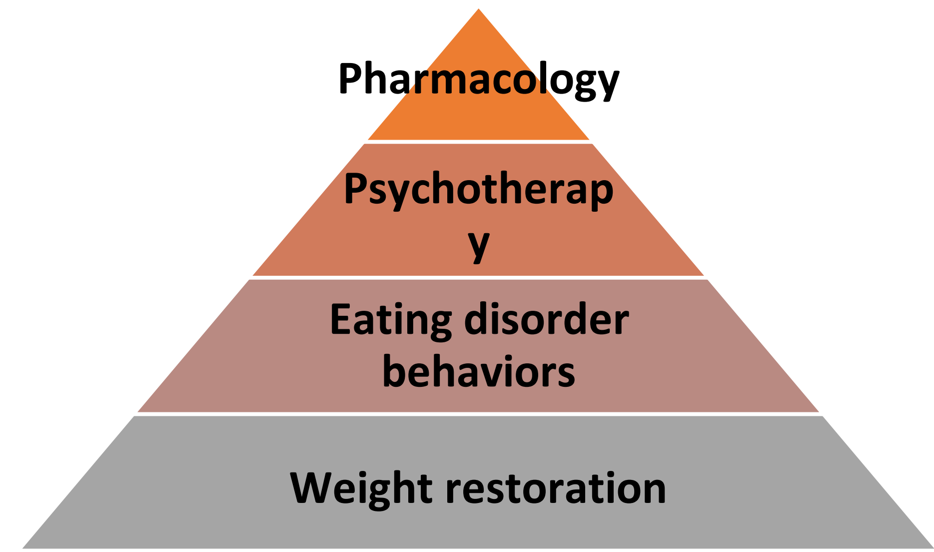
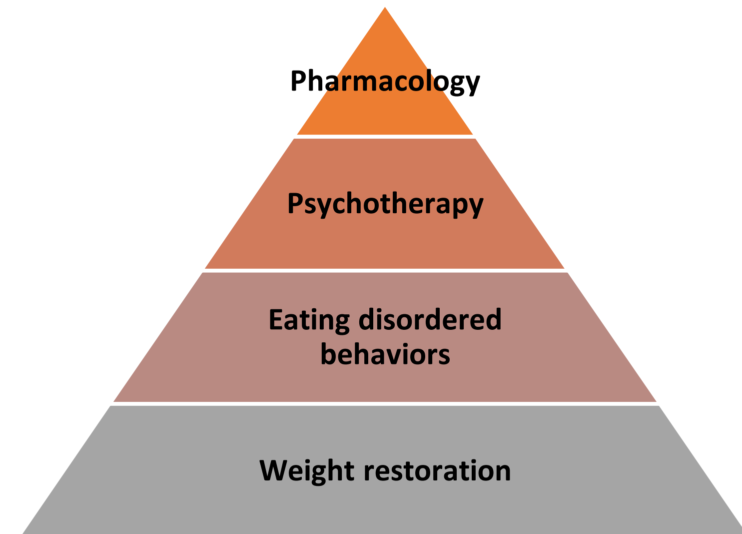
Diagnose and Then?

- Once you have identified a patient with an eating disorder, you need to take steps to get them the treatment they need
- Earlier diagnosis and treatment is associated with better outcomes



Weight Restoration

- Increase caloric intake
  - Starts at ~1200-1400kCal/day
  - Gradually increased to 3,000-4,000kCal/day depending on rate of weight gain
- Target weight gain:
  - 0.5-1lb/wk outpatient
  - 2-3lb/wk inpatient



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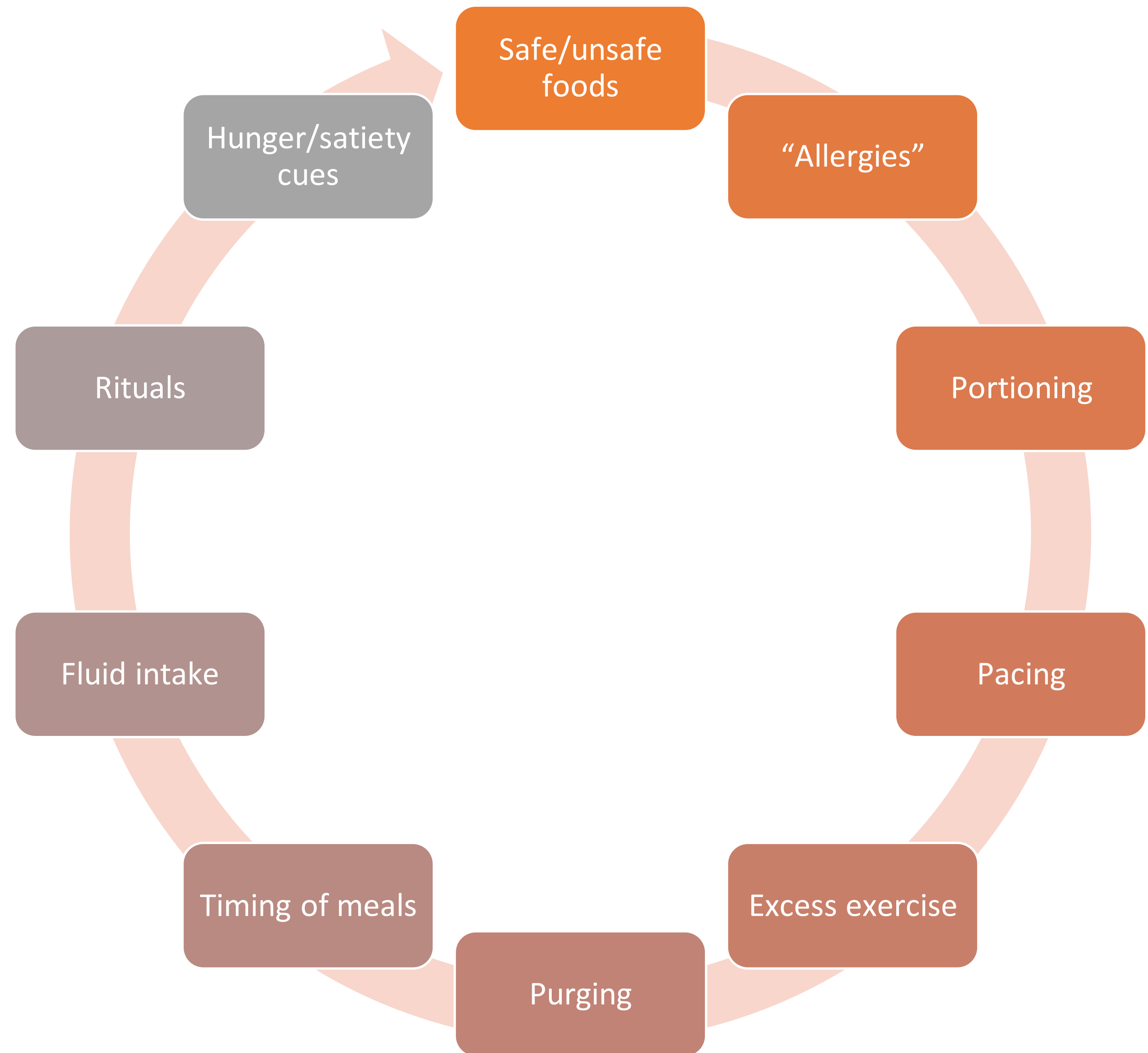
Eating Disorder Behaviors



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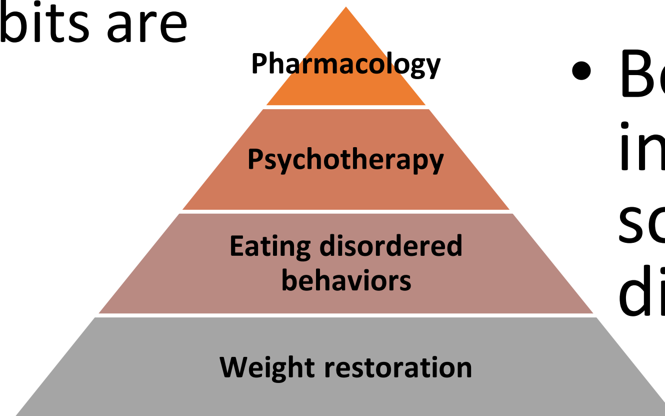
Anorexia Nervosa Treatment

Anorexia nervosa: Adolescents

- Family Based Therapy has the most robust evidence
  - Caregivers take control of eating choices
  - Teaches the family how to support the child as food habits are normalized



Anorexia nervosa: Adults

- No one therapy has proven to be superior
- Nutritional counseling + Therapy is better than nutritional counseling alone
- Bottom Line: Get the patient into therapy, preferably with someone experienced in eating disorder treatment

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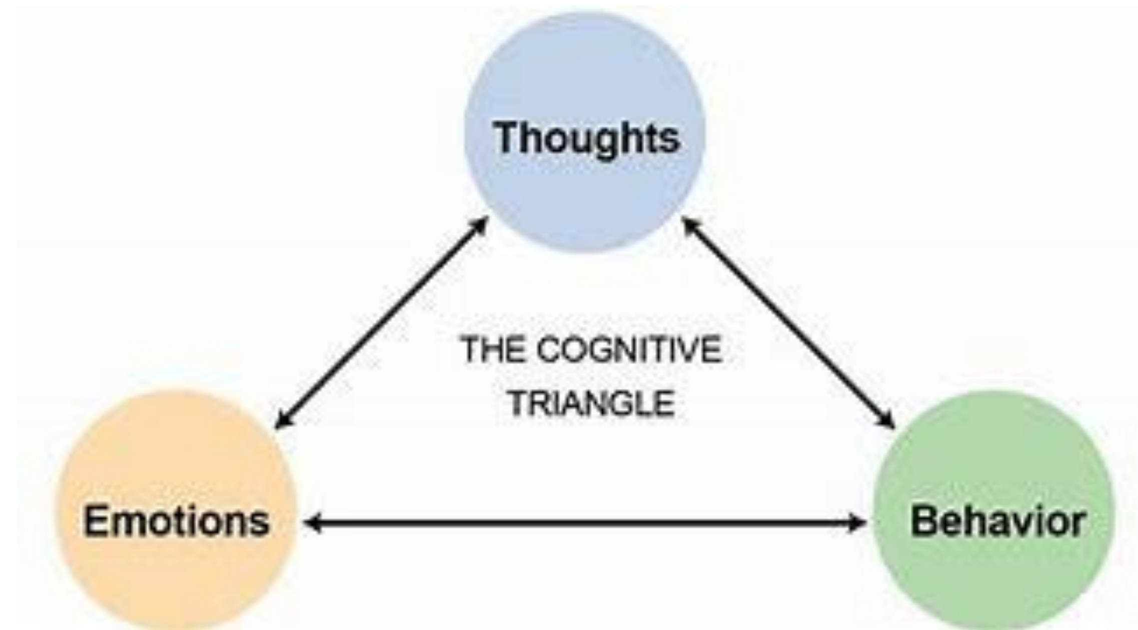
Bulimia Nervosa & Binge Eating Treatment

- Good evidence that Cognitive Behavioral Therapy is the ***most effective intervention***



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Step Away From The Prescription Pad…

- Commonly Prescribed Psychotropic Medications (uw.edu)
- What all has been tried for Eating Disorder Treatment?
- What is actually effective?

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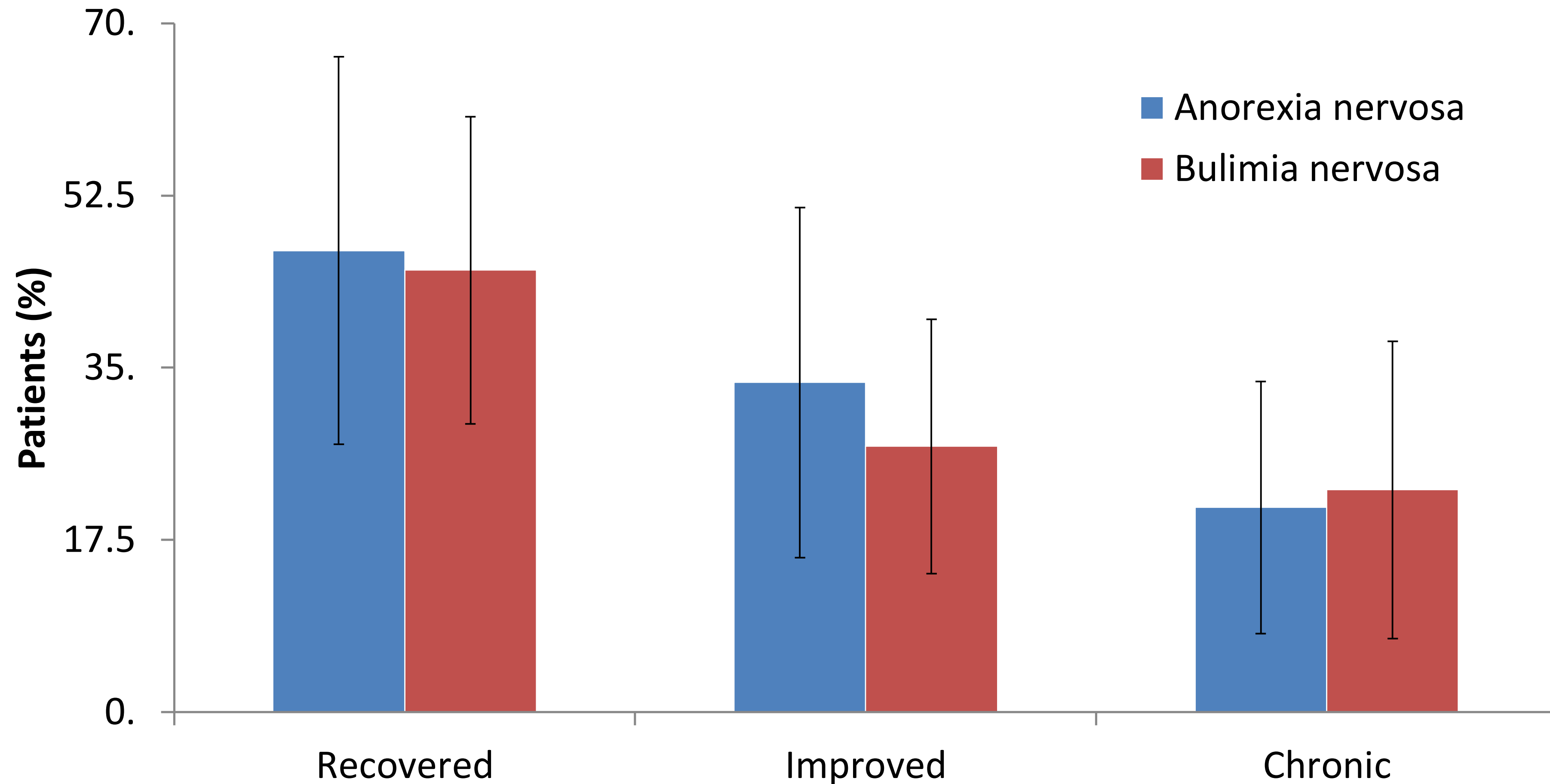
Recovery



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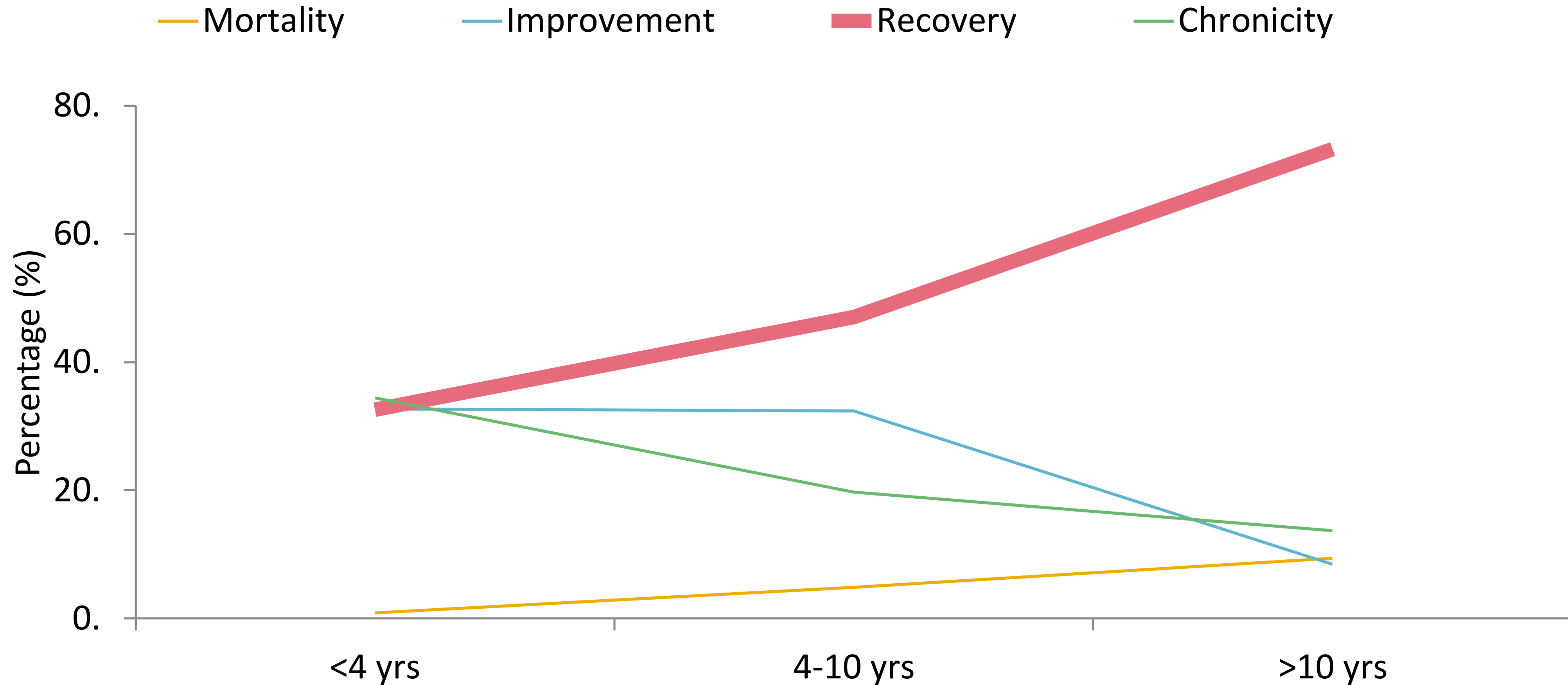
Recovery: Anorexia Nervosa



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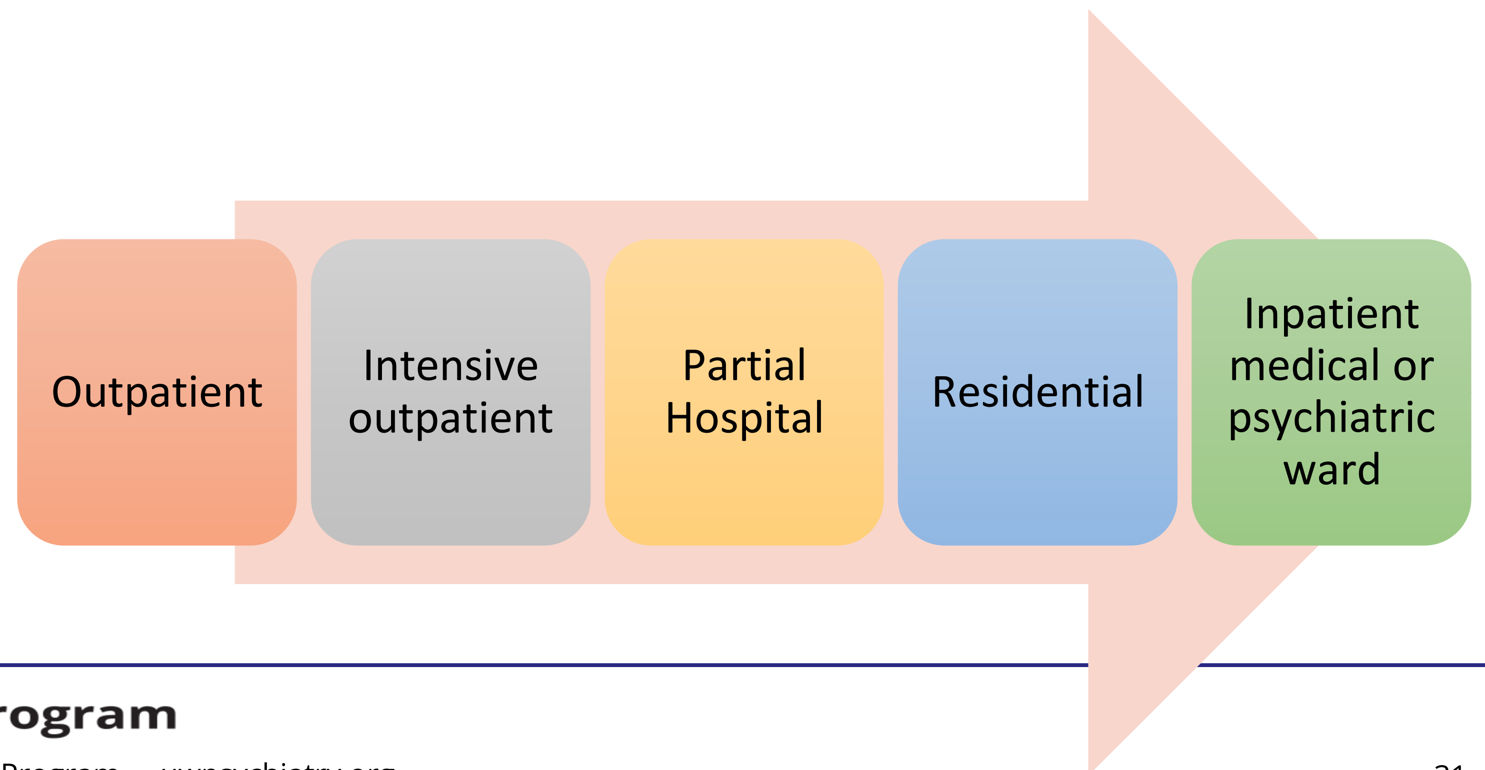
When to Refer and When to Treat as an Outpatient

- Whether a patient should be hospitalized for treatment depends on a number of factors
  - Medical stability
  - Comorbid psychiatric issues
  - Willingness to engage in treatment



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Outpatient Care

- Medically Stable
- Not Suicidal
- >85% IBW
- Fair to Good Motivation
- Adequate Support System
- Self-sufficient in Weight Restoration
- Able to Care for Self
- Able to Exercise for Fitness and Able to Control This
- Able to Control Purging and Have no Medical Complications Related

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Principles of Collaborative Care

	Accountable Care Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

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Patient-Centered Integrated Behavioral Health Care Principles & Tasks Checklist

CollaborativeCarePrinciplesAndComponents_pg1UPDATED (uw.edu)

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Key Takeaways

- Screen!
- Early treatment is associated with better outcomes
- Weight restoration is key for AN, followed by therapy and ongoing nutritional support
- SSRIs & CBT are best supported for BN & BED
- These patients get better – be patient!

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Resources

- AIMS Center office hours
- UW PACC
- Psychiatry Consultation Line
  - (877) 927-7924
- Partnership Access Line (PAL)
  - (866) 599-7257
- PAL for Moms
  - (877) 725-4666
- UW TBI-BH ECHO

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