Eating Disorder Treatment Protocol

All Team Members: Patient Self-Management Education & Support

Eating Disorders are incredibly debilitating and are associated with significant medical and psychosocial comorbidity. The main 3 eating disorders that are seen in the general population are Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder.

Anorexia Nervosa is characterized by a gross distortion of one's sense of their weight or body shape. This distortion can be quite extreme, and can include a person who is so underweight that they require the use of a feeding tube to provide nutrition, and yet they continue to think of themselves as fat or overweight. Anorexia Nervosa can be a life-threatening condition, as nutritional deficiencies can lead to very significant medical problems, such as cardiac dysrhythmias due to electrolyte imbalances and hypotension. When a patient with Anorexia Nervosa becomes dangerously underweight, and is not willing to eat food, they may require admission to a hospital for nutritional rehabilitation. Psychotherapies have the strongest evidence supporting their use in treatment. Medications have not been shown to help much, with the exception of atypical antipsychotics, which can help with some of the emotional and cognitive problems associated with Anorexia Nervosa. One important form of nutritional replacement is Zinc, and other deficiencies need to be repleted as well. Severity in DSM V is based on the BMI, which is a main clinical outcome in the treatment of Anorexia Nervosa.

Bulimia Nervosa is characterized by bingeing and then engaging in inappropriate compensatory behaviors in order to prevent weight gain. It is important to note that individuals with Anorexia Nervosa can and often do also engage in inappropriate compensatory mechanisms to prevent weight gain, but do not commonly engage in bingeing. Psychotherapy, especially CBT has been shown to have utility in the treatment of Bulimia Nervosa. Likewise, use of self-help materials, such as work books is an established methodology with proven utility. Treatment with antidepressant medications is the mainstay as far as medication treatment in Bulimia Nervosa.

Binge Eating Disorder is similar to Bulimia Nervosa, in that both include bingeing. However, in Binge Eating Disorder, there are no inappropriate compensatory behaviors associated with the bingeing. As with Bulimia Nervosa, CBT and self-help groups and workbooks have shown efficacy. Treatment with antidepressants has also been shown to be helpful with this disorder.

Sleep hygiene	Patients should use their bed for sleep and sex only. Move the television out of the bedroom. Develop a regular and relaxing routine for bedtime. Set a regular time to get up and get dressed each day. Drink caffeinated beverages (if at all) in the morning only.
Exercise	Exercise can be helpful for the treatment of depression co-morbid with eating disorders, however, if exercise is excessive, it may be a focus of clinical interest, and decreasing the duration or frequency may be indicated.
Social activation	People with eating disorders may isolate themselves and constantly think about food and their body. It is important that they stay connected with family and friends, even if they do not feel like it. They should schedule meetings and activities that they used to enjoy. This is adopting the “fake it until you make it approach.”
Quit drugs. Limit alcohol	Many illicit drugs, like cocaine and methamphetamines, may be used as an appetite-suppressant. Alcohol may decrease food and body associated anxiety in the short-term, but can worsen anxiety in the long-term. Alcohol makes falling asleep easier, but staying asleep harder. Alcohol use also increases risk of suicide. Support your patients to quit.
Limit tobacco and caffeine	Both tobacco and caffeine are stimulants and may be used to curb appetite. Decreasing the amount of (or not using) caffeine and tobacco can make anxiety much better, but may be difficult as a result of eliminating a mild appetite supressant.
Practice mindfulness	Mindfulness **techniques may include sitting or walking**

techniques or do CBT homework	**meditation, yoga, and the body scan.** CBT homework may include writing down automatic thought and behavior patterns and thinking about underlying belief systems
Take medications as directed	Patients may be prescribed: - Antidepressants - Antipsychotics Talk to patients to see if they are taking their prescribed medicines and if there are barriers to adherence. Many patients also take dietary supplements, alternative medications (such as SAMe) or herbal medications. Ask about these so that you can see if there are toxic side effects or interactions with prescribed medicines.

Educate the patient about warning signs of worsening anxiety or risk of suicide and when to call the team:

- Persistent thoughts of hurting or killing themselves, especially with a specific plan
- Access to weapons or other dangerous means of hurting themselves
- Substance abuse or increased use
- Increasing social isolation: not spending time with other people
- Increasing anhedonia: not enjoying the things/activities they used to enjoy
- Increasing feelings of hopelessness or feeling helpless to control their worrying
- Increasing difficulty with sleep
- Increasing irritability or arguing with friends and family
- Increasing number or severity of panic attacks
- Increasing worry or fear of the next panic attack which leads to avoidance of usual activities
- Increasing problems at work or school
- Difficulty doing the basic activities of daily life (food preparation, paying bills, keeping themselves clean)
- Medication side effects that are bothersome

NP: Diagnosis

Anorexia Nervosa (DSM V Criteria)

A. 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
B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight

C. Disturbance in the way that 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
    a. **Severity**:
        i. BMI 17 or over: mild
        ii. BMI 16-16.99: Moderate
        iii. BMI 15-15.99: Severe
        iv. BMI under 15: Extreme

Bulimia Nervosa (DSM V Criteria)

A. Recurrent episodes of binge eating. Binge eating is characterized by both of the following:
    a. Eating, in a discreet period of time (eg. 2 hours) an amount of food that is definitely larger than what most individuals would eat in a similar period of time, in similar circumstances
    b. A sense of lack of control over eating during the episode (eg. A feeling that one cannot control what or how much one is eating)
B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics or other medications; fasting; or excessive exercise
C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months
D. Self-evaluation is unduly influenced by body shape and weight
E. The disturbance does not occur exclusively during an episode of anorexia nervosa
    a. **Severity:**
        i. 1-3 inappropriate compensatory episodes per week: Mild
        ii. 4-7 inappropriate compensatory episodes per week: Moderate
        iii. 8-13 inappropriate compensatory episodes per week: Severe
        iv. 14 or more inappropriate compensatory episodes per week: Extreme

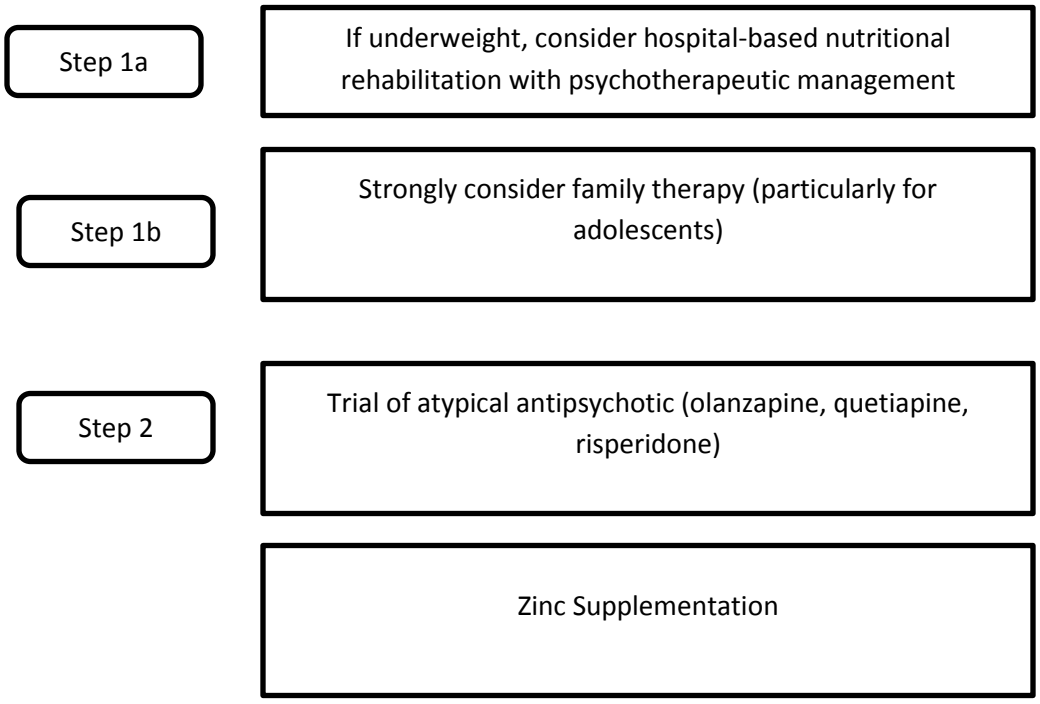
Binge Eating Disorder (DSM V Criteria)

A. Recurrent episodes of binge eating. . Binge eating is characterized by both of the following:
    a. Eating, in a discreet period of time (eg. 2 hours) an amount of food that is definitely larger than what most individuals would eat in a similar period of time, in similar circumstances
    b. A sense of lack of control over eating during the episode (eg. A feeling that one cannot control what or how much one is eating)
B. Binge eating episodes are associated with 3 or more of the following:

a. Eating much more rapidly than normal
b. Eating until feeling uncomfortably full
c. Eating large amounts of food when not feeling physically hungry
d. Eating alone because of feeling embarrassed about how much one is eating
e. Feeling disgusted with oneself, depressed, or very guilty afterward

C. Marked distress regarding binge eating
D. Binge eating occurs, on average, at least once a week for 3 months
E. Binge eating is not associated with inappropriate compensatory behaviors, such as in bulimia, and is not occurring during a course of bulimia nervosa or anorexia nervosa
   a. **Severity:**
      i. 1-3 binge eating episodes per week: Mild
      ii. 4-7 binge eating episodes per week: Moderate
      iii. 8-13 binge eating episodes per week: Severe
      iv. 14 or more binge eating episodes per week: Extreme

Algorithm for treatment of Anorexia Nervosa (Adapted from the American Psychiatric Association Guideline for treatment of patients with eating disorders, 3rd Ed, 2012)



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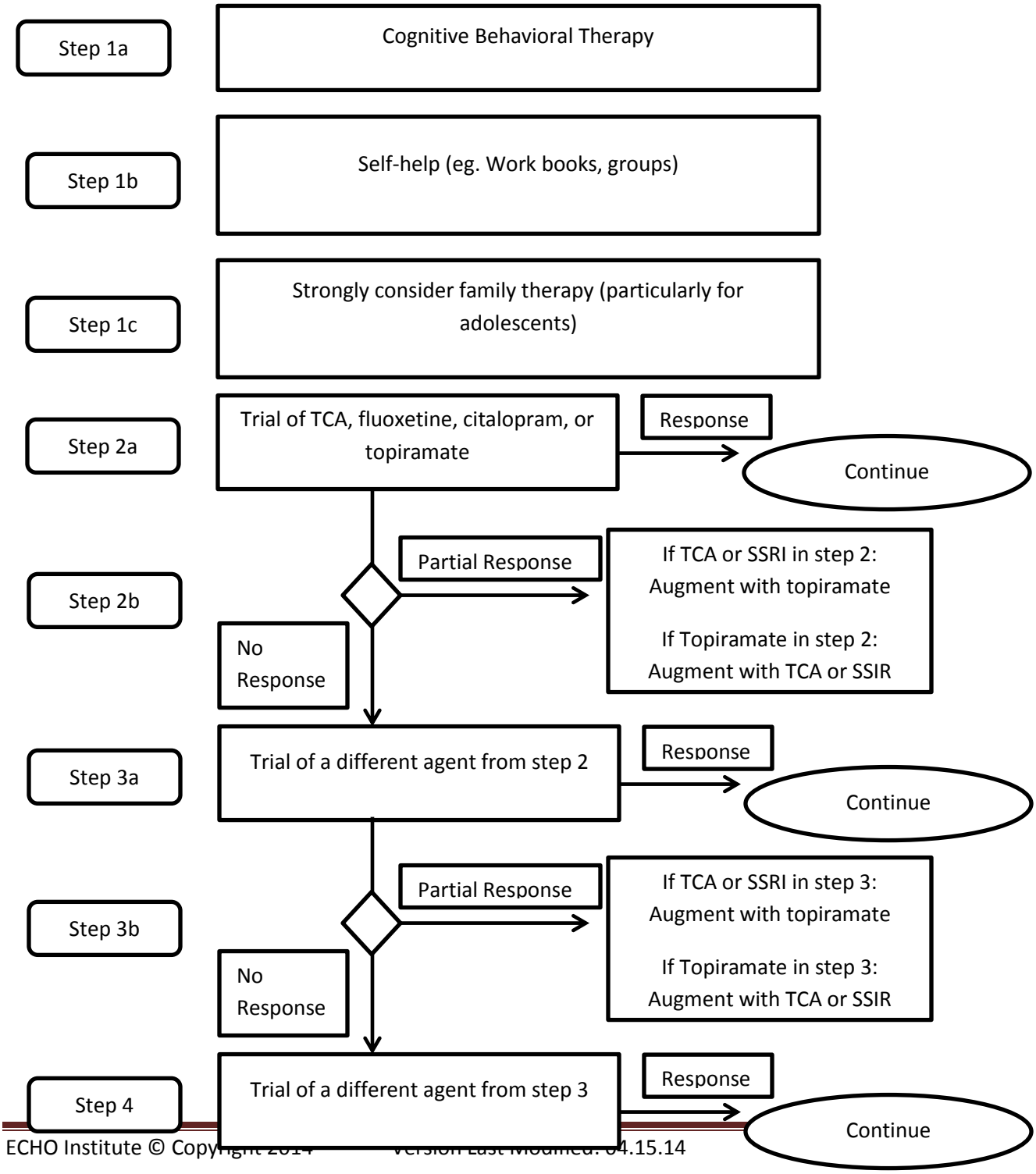
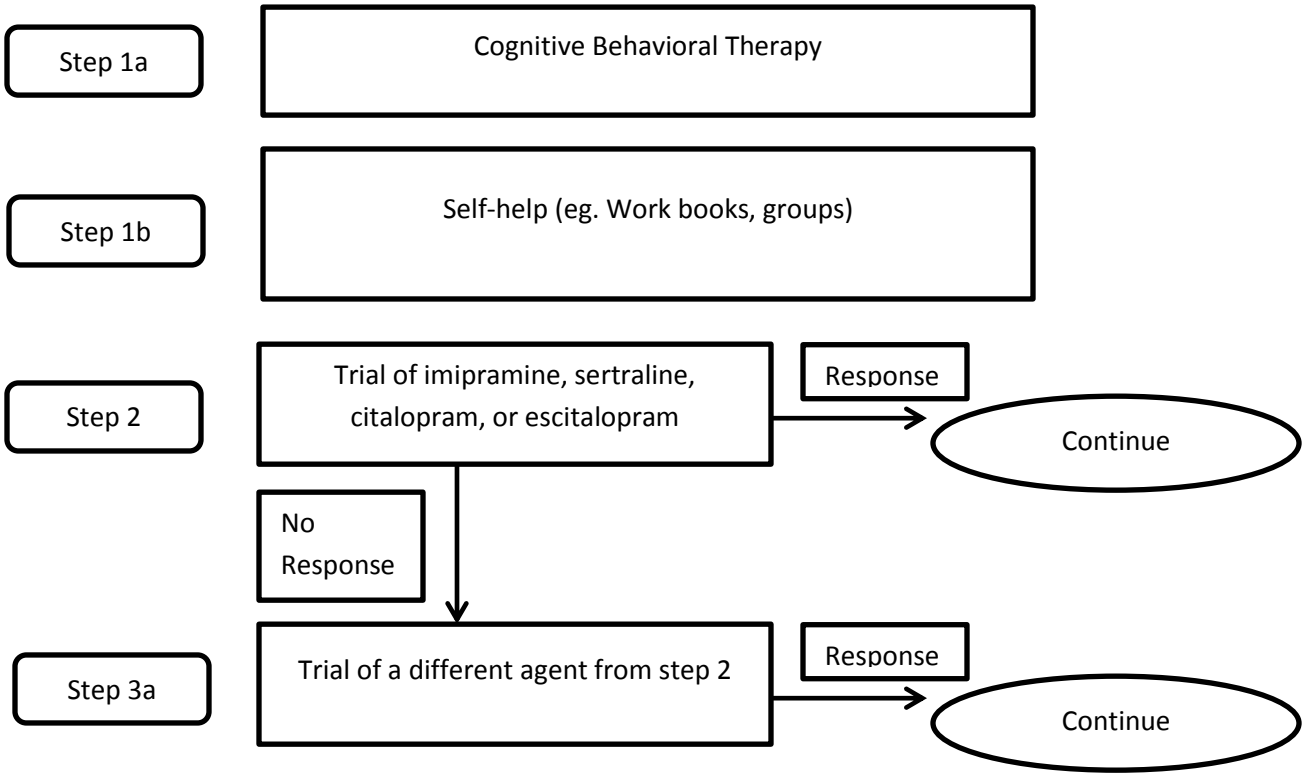


Algorithm for treatment of Binge Eating Disorder (Adapted from the American Psychiatric Association Guideline for treatment of patients with eating disorders, 3rd Ed, 2012)



CHW:

I. Medication reconciliation: review which meds the patient is taking, how/when they are taking, barriers to use, etc

II. Substance Abuse Assessment: (caffeine, cocaine, amphetamines, cannabis, PCP, hallucinogens alcohol, benzodiazepines). Perform motivational interviewing and supportive counseling around these topics. Make appropriate referrals to supportive groups and detox/cessation programs

III. Suicide Risk Assessment at every visit
   a. Ask about suicidal thoughts, plans, means, and behaviors
   b. Ask about past suicidal behavior or family history of suicide
   c. Talk about current stressors
   d. Assess possible protective factors such as reasons for living

IV. Review patient self-management goals ("change plan"). Perform motivational interviewing around these goals. May include: Sleep hygiene, exercise, social activity, decreasing substance use, MBSR techniques or CBT homework, regular medication use, etc.

V. Explore if any social pathways need to be added, revisited or updated.
   a. Consider referrals to county/state agencies for Medicaid, other funding assistance (likewise for federal agencies—e.g., for SSI, SSDI, Medicare, etc.)
   b. Consider referrals to subsidized housing.
   c. Consider referrals to supported employment.

When to present to Project ECHO

   a. Moving beyond first line treatment
   b. Poor response to treatment or not tolerating treatment
   c. Significant medical comorbidity
   d. Poor adherence to treatment
   e. Questions about counseling techniques
   f. Other confounding symptoms, ie paranoia, moodiness, self injurious behaviors, suicidality