

Medication-Assisted Eating Disorders

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Disclosures

I have no conflicts of interest to disclose.

Eating Disorders in the US

- Why should I learn about this?

Eating Disorders in the US

- Why should I learn about this?
 - **Early recognition and treatment** are key to good outcomes
 - You don't have to be an eating disorder specialist to help a patient with an eating disorder. Yet, **training for providers are limited**.
 - Therefore, **access to care for patients are limited**

Today's Talk

Focus on a medical psychiatry aspect of eating disorders care for general psychiatrists and other MH providers who are not eating disorder specialists, with goals of:

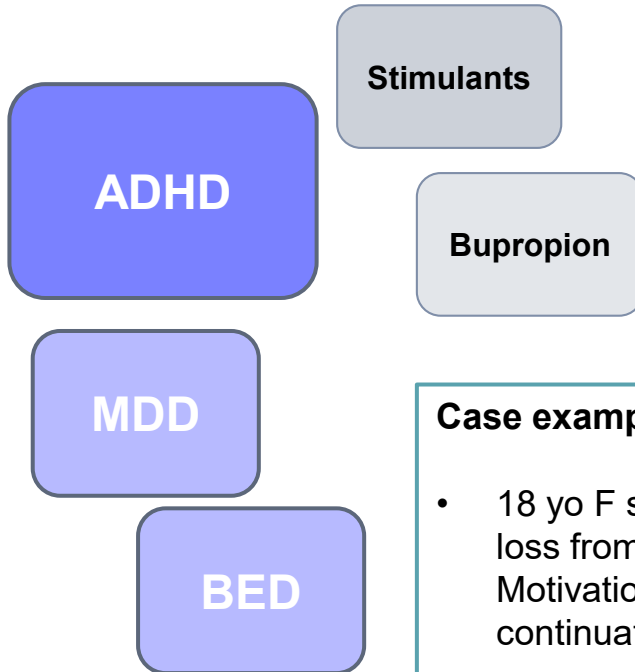
- Brief reviews of select **DSM-5 ED diagnoses**
- Describing **medication treatment/misuse** contributing to eating disorders to **enhance problem recognition**
- **Practical approaches** to clinical management

Select topics, not a comprehensive review

Overview

1. Appetite- or weight-suppressant medications
2. Insulin misuse in type 1 diabetes
3. Gastrointestinal symptom management in anorexia nervosa

Appetite/Weight Suppressing Medications



Case example

- 18 yo F started on stimulants for ADHD. Weight loss from BMI 21 to BMI 16 over 6 months. Motivation to maintain thinness drives continuation of restrictive eating. Develops AN-R.

Anorexia Nervosa

Table 1. Diagnostic Criteria for and Subtypes and Severity of Anorexia Nervosa.

Diagnostic criteria*

Restriction of energy intake relative to requirements, leading to significantly low body weight for the patient's age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than the minimal normal weight or, in children and adolescents, less than the minimal expected weight.

Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though the patient has a significantly low weight.

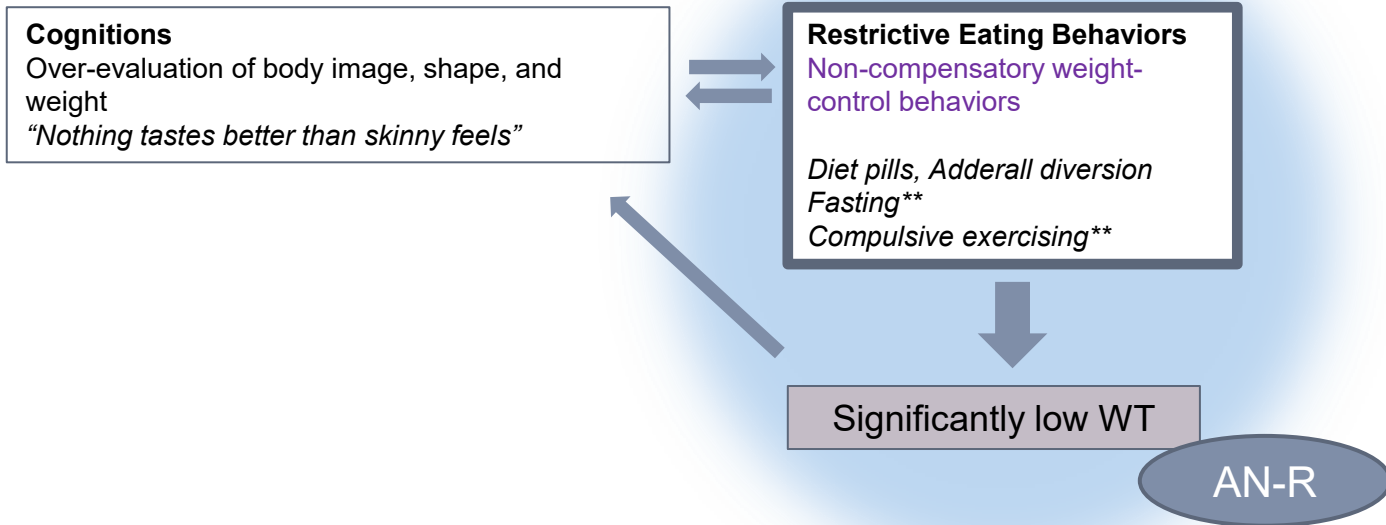
Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Extreme restriction
resulting in
low body weight

Behaviors (or intense fears
driving behaviors) that
interfere with weight gain

Cognition
overvaluation of weight or
shape, or lack of insight

Anorexia Nervosa



Anorexia Nervosa

Cognitions

Over-evaluation of body image, shape, and weight

"Nothing tastes better than skinny feels"



Restrictive Eating Behaviors

Non-compensatory weight-control behaviors

Diet pills, Adderall diversion

*Fasting***

*Compulsive exercising***

Purging Behaviors

Compensatory weight-control behaviors

Self-induced vomiting

Laxative misuse

Compensatory

*fasting/exercising***

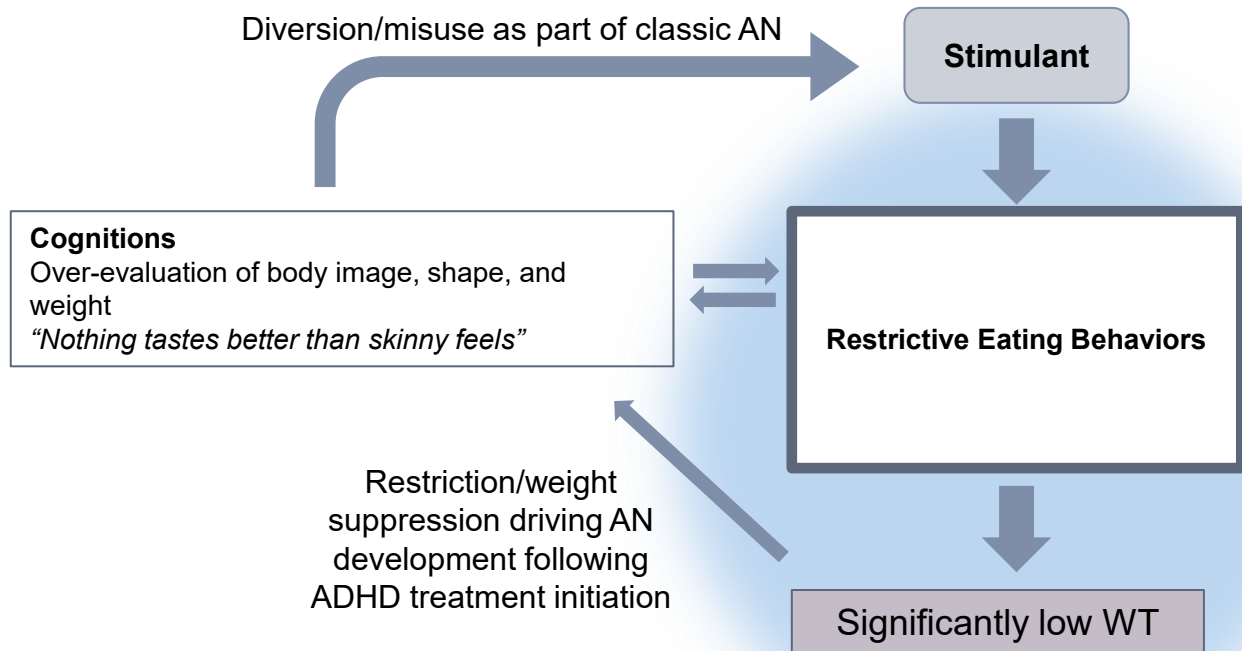


Binge-eating

Significantly low WT

AN-BP

Anorexia Nervosa



ADHD Medications

ADHD treatment with dopaminergic agents can result in rapid **weight suppression that can subsequently drive anorexia nervosa**. Individuals with eating disorders can have impairments in the attentional axis, premorbid to or as a result of their ED.

Practical treatment approach

1. Prioritize **addressing ED > ADHD** (i.e., “food = medicine” approach), and also address ADHD as part of motivational interviewing for ED recovery
2. Treat ADHD with stimulant options, if ED is adequately being addressed and ADHD is severe (i.e., clear plan with milestones for ED treatment response; demonstrates ability to eat sufficiently)
3. Treat ADHD with nonstimulant options, if lacking ability to eat sufficiently due to ED
4. Treat ADHD with nonpharmacologic options (executive function coaching)

Appetite/Weight Suppressing Medications

Obesity

Stimulant

Multimodal
AED

NDRI

Opioid R
blocker

Fat absorption
blocker

1999

Apr 26,
1999



**ORLISTAT
(XENICAL®)**

120 mg
three times daily

2012

Jul 17,
2012



QSYMIA®
(phentermine/
topiramate ER)

7.5/46 mg –
15/92 mg daily

2014

Sep 10,
2014



CONTRAVE®
(naltrexone HCl/
bupropion HCl)

8/90 mg –
32/360 mg daily

GLP-1 or GLP-1
+ GIP agonist

2014

Dec 23,
2014



SAXENDA®
(liraglutide injection)
0.6 mg – 3.0 mg
once daily

2021

Jun 4,
2021



WEGOVY®
(semaglutide
injection)
0.25 mg – 2.4 mg
once weekly

2023

Nov 8,
2023



ZEPBOUND®
(tirzepatide
injection)
2.5 mg – 15 mg
once weekly

2025

Dec 22,
2025



WEGOVY®
(oral semaglutide)
25 mg once daily

2026

Apr 1,
2026



**ORFORGLIPRON
(FOUNDAYO™)**
36 mg once daily

Figure courtesy of Dr Ahmad Bahareth

Appetite/Weight Suppressing Medications

Obesity

- **Patients without obesity** – can access with no in-person or virtual evaluation.

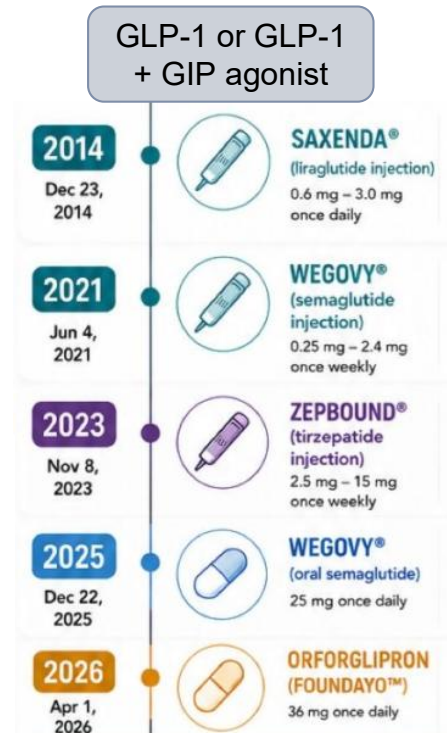


Figure courtesy of Dr Ahmad Bahareth

Appetite/Weight Suppressing Medications

Obesity

Case examples

Binge-Eating Disorder

Cognitions: (weight/shape concerns)

Behaviors:

Binge-eating episodes

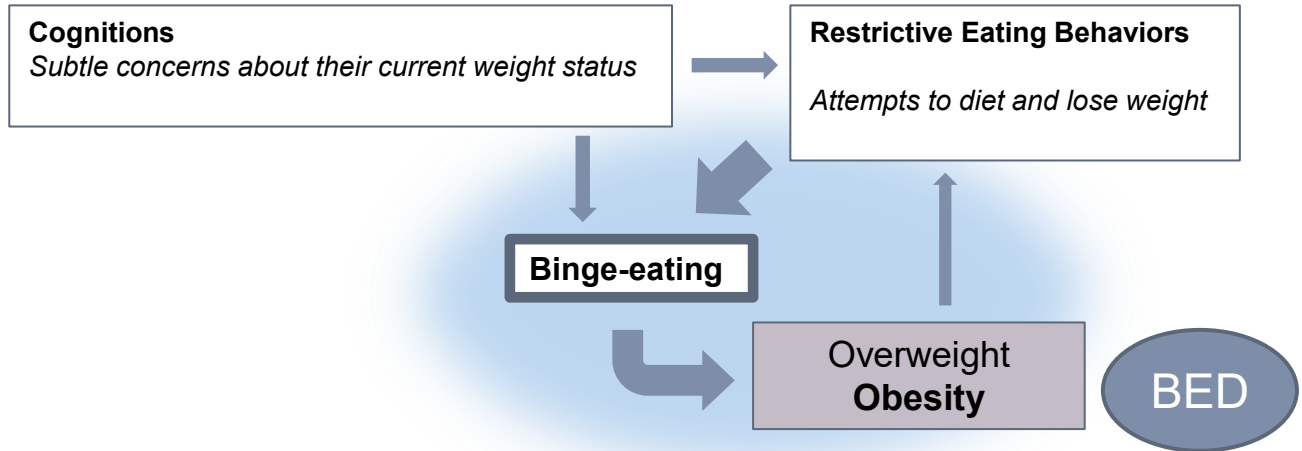
NO compensatory behaviors

Occurs at least 1x/week for 3 months

Mild (1-3x/wk binge), Moderate (4-7x), Severe (8-13x), Extreme (14+)

Body Weight: Overweight, **Obese**

Binge-Eating Disorder



Bulimia Nervosa

Cognitions: **self-evaluation influenced by shape/weight concerns**

Behaviors:

Binge eating episodes

- Eating in a discrete period of time (ie 2 hours) an amount of food that is objectively larger than what others would eat in a similar context
- Sense of loss of control

Compensatory behaviors

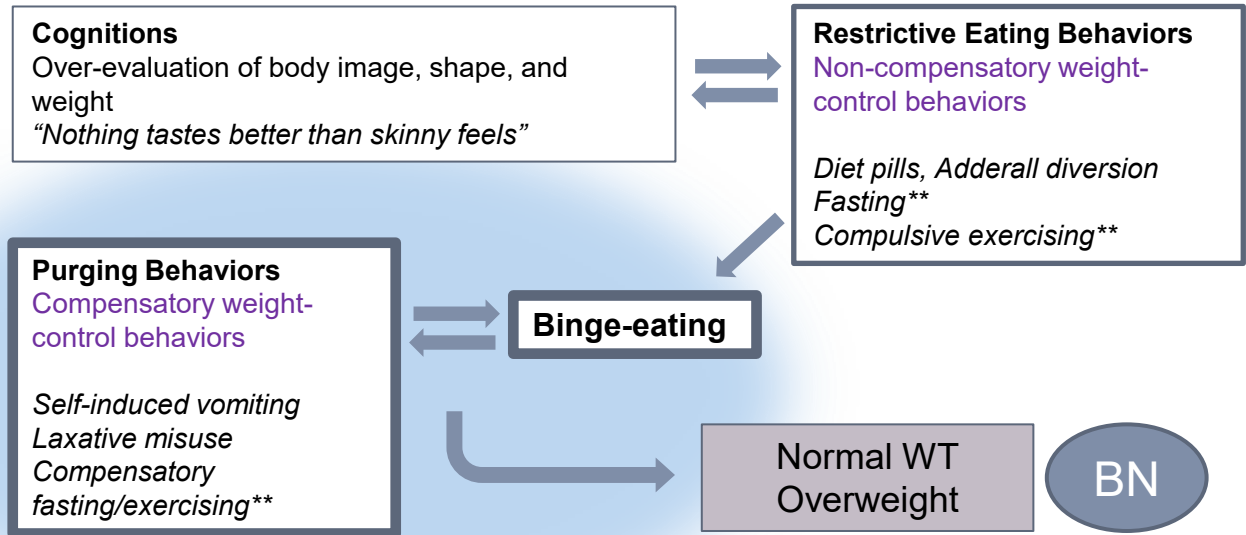
Vomiting, laxatives, diuretics, compensatory and excessive exercise

Both occur at least 1x/week for 3 months

Mild (1-3x/week purging), Moderate (4-7x), Severe (8-13x), Extreme (14+)*

Body Weight: **Normal, Overweight, Obese**

Bulimia Nervosa



Obesity Medications

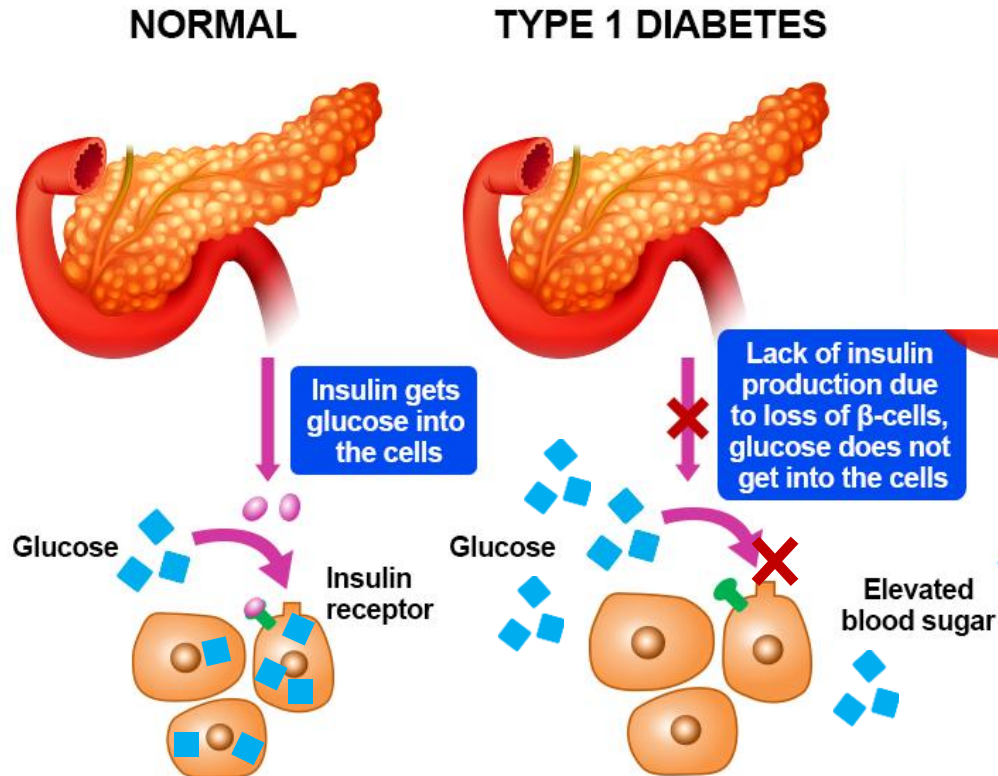
Practical treatment approach

1. AN from misuse of obesity medications: **behavioral therapy** with dual goals (1) cessation of obesity medication misuse; (2) weight restoration through regularizing eating
2. BN/BED during treatment of obesity with obesity medications:
 - **CBT-E** to stop binge/purge through regular eating + **high-dose SSRI** would have been first line for traditional BN
 - Blindly re-increasing GLP-1/GIP dose back to pre-taper dose after development of BN may not always result in cessation of behaviors.
 - Short, time-limited trial of **CBT**. If not effective, small dose increase in GLP-1/GIP in discussion with obesity treater. Re-trial of **CBT**.
3. **Communicate and coordinate care** with obesity team

Bulimia Nervosa with Insulin Misuse

Bulimia Nervosa with Insulin Misuse

Type 1 Diabetes



Bulimia Nervosa with Insulin Misuse

Type 1 Diabetes

First-line treatment = insulin injections

- Too much insulin – hypoglycemia; can result in **fluctuations in mood/cognition/hunger** (i.e., “hangry”, “brain fog”)
- Clinical need for **food tracking/carb counting** – vulnerability to preoccupation with food/eating
- Insulin treatments are associated with longer-term **weight gain** – vulnerability to developing weight/shape concerns

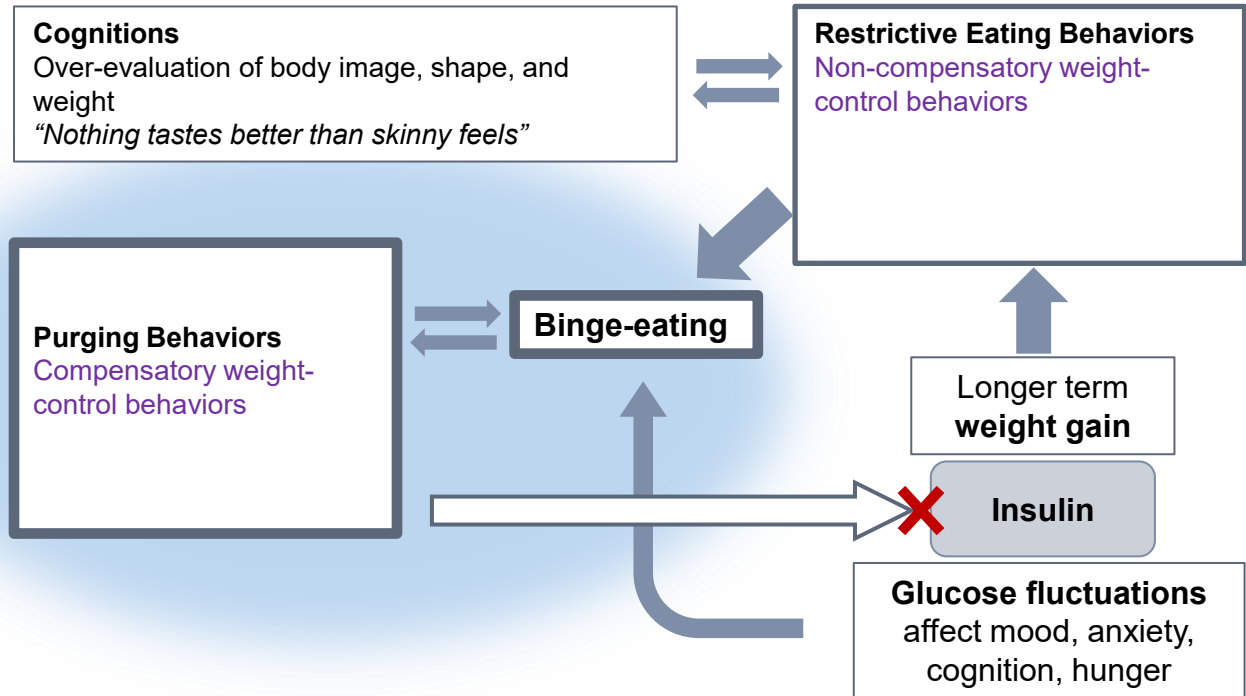
Bulimia Nervosa with Insulin Misuse

Type 1 Diabetes

First-line treatment = insulin injections

- Too little insulin – hyperglycemia; can result in **diabetic ketoacidosis (DKA)** –
 - ~40% youth experience DKA at the time of diagnosis
 - Fat broken down to ketones because cells cannot use glucose without insulin
 - Life-threatening emergency

Bulimia Nervosa with Insulin Misuse



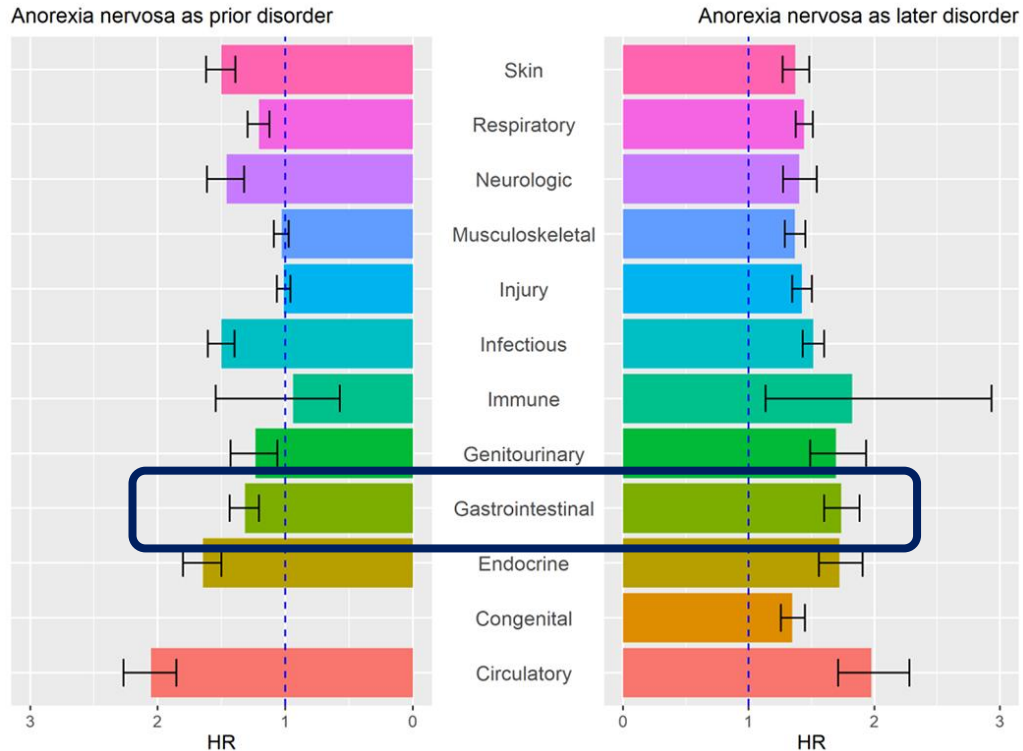
Diabulimia

Practical treatment approach

1. CBT-E to stop binge/purge through regular eating + **high-dose SSRI** would have been first line for traditional BN
2. Similar treatment approach to diabulimia. **Prioritize cessation of purging by insulin restriction.** Address other purging behaviors and binge-eating. Special attention to **cognitive aspects (“brain fog”)** of poor glycemic control, or *functional ADHD*.
 - **Motivational** tool for eating disorder recovery
 - Therapy or coaching for **organizational skills/productivity.**
 - Consider **non-stimulant ADHD medications** - caution against stimulant treatments with active purging (cardiac risk)
 - For all medication treatments, consider possible alterations in CYP450 enzyme levels/activity in patients with poor glycemic control
3. **Communicate and coordinate care** with diabetes team

GI Symptoms in Anorexia Nervosa

GI Symptoms in Anorexia Nervosa



Momen NC, et al. *N Engl J Med*. 2020.

Momen NC, et al. *Br J Psychiatry*. 2022.

GI Symptoms in Anorexia Nervosa

Systematic review showed patients with AN more likely vs comparator to have

- Delays in gastric motility and emptying, intestinal transit
- Potential symptoms:
 - Acid reflux, bloating, belching
 - Early satiety/fullness, abdominal pain, nausea
 - Slow-transit constipation
- Symptoms develop as an **adaptation to undereating**, then becomes a part of the **maintaining mechanisms of AN** (barrier to eating)

GI Symptoms in Anorexia Nervosa

Practical treatment approach

1. **Prioritize treatment of AN**, as evidence base shows all symptoms of delayed gastric emptying improves with completion of renutrition treatment for AN (Rigaud et al. 1988). **Motivate towards AN recovery w/r/t GI symptoms.**
2. **Treat GERD** – antihistamine (e.g., famotidine) trial; if no improvement, consider short-term PPI (e.g., omeprazole) with consideration of DDI.

GI Symptoms in Anorexia Nervosa

Practical treatment approach

3. GI motility agents (e.g., metoclopramide) – behavioral considerations
 - If patients can be encouraged to **push through the discomfort** to complete meals with behavioral supports (family-based treatment, HLOC treatment, etc.), **consider holding off** (food = medicine).
 - Consider starting **only if substantial inability to eat presents a barrier in treatment of AN** (i.e., intractable nausea/vomiting).
 - If low motivation and effort to complete meals despite treatment with motility agent, **consider stopping** – delayed GI motility is part of the normal physiology in those who undereat. Treatment of symptoms for the sake of reducing just the GI symptoms, adds unnecessary risk and may be “**in collusion with AN**” to perpetuate the AN by reducing motivational reward to recover from AN (i.e., improvement in GI symptoms)

GI Symptoms in Anorexia Nervosa

Practical treatment approach

4. Constipation

- **Weight restoration** to target AN will improve constipation (Chun et al 1997).
- Treat constipation **to assist with treatment of AN**. Sufficient **hydration** and **food**. Standing **fiber** (e.g., Metamucil BID). **Osmotic laxatives** PRN (i.e., Magnesium PRN or Miralax PRN for severe pain from constipation or no BM in 3+ days; prune juice). Push through mild discomfort if tolerable (food = medicine).
- If low motivation and effort to complete meals despite heavy bowel regimen, **consider simplifying regimen** – chronic restriction with heavy-handed constipation treatment often result in polypharmacy for constipation treatment for the sake of improving just the GI symptoms, which may be “**in collusion with AN**” to perpetuate the AN by reducing motivation to recover from AN (i.e., improvement in GI symptoms).

GI Symptoms in Anorexia Nervosa

GI issues in AN

Case examples

53 yo F with 40-year history of AN

- Heavy purging by *laxative misuse* early in illness, followed by chronic restriction with *laxative treatment*
- Now unable to have BM without:
 - fiber PRN
 - polyethylene glycol (Miralax) TID
 - Magnesium 400 mg TID
 - docusate (Colace) 200 mg TID
 - bisacodyl (Dulcolax) EC 5 mg TID
 - senna (Senokot) 17.2 mg qHS
 - metoclopramide (Reglan) 10 mg TID
 - prucalopride (Motegrity) 2 mg daily
 - Weekly clean-out with suppository/enema, started in residential treatment 20+ years ago and continued after.
- **Still feels constipated every day.**

Medication-Assisted Eating Disorders

Summary

1. **Prioritize treatment of eating disorder.**
2. **Behavioral therapy to stop misuse of medications** for ADHD, obesity, type 1 diabetes, as weight control behaviors.
3. GI symptoms in AN will recover with treatment of AN. **Refrain from overtreatment of GI symptoms** in the absence of engagement in AN treatment.
4. **Communicate and coordinate care** with medical care teams

Practical Approach to Eating Disorders

Practical approach: what can you do with every patient with ED?

Practical Approach to Eating Disorders

Motivate the patient to **want** to recover

Combination of MI + **CBT**

What the patient wants in life

Risks of not recovering

Practical Approach to Eating Disorders

Provide information on **how** to recover

Anorexia Nervosa

Weight restoration to sufficiently high weight

Maintenance of the restored body weight for a sufficiently long duration

...through **regular eating**

Practical Approach to Eating Disorders

Provide information on **how** to recover

Bulimia Nervosa/Binge-Eating Disorder

Regular eating

Cessation of weight control behaviors

Practical Approach to Eating Disorders

Support

Supervision

Safety

Design a game **plan** towards full recovery

Practical Approach to Eating Disorders

Motivate the patient to **want** to recover

Provide information on **how** to recover

Design a game **plan** towards full recovery

Thank you for your attention

Questions?