Establishing Boundaries and Navigating Levels of Care Discussions

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Learning Objectives

- Describe what a boundary is, the general principles of how to set and honor boundaries and explore your own limits regarding boundary-setting.

- Explain criteria that would make a patient with an eating disorder appropriate for: (1) outpatient care, (2) higher levels of outpatient care, such as IOP or PHP, (3) ER referral for possible inpatient refeeding, and (4) inpatient eating disorder care.

- Differentiate between patient cases requiring different levels of care, and apply boundary setting when patients decline treatment recommendations.

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Setting Boundaries with Patients

- Hearing “setting boundaries” likely evokes something in you – recalling past experiences, feelings or thoughts. Take a moment to think about that.

- Do you feel you are able to set boundaries with patients?

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What is a Boundary?

- Many times, we feel like we need to set a boundary when someone else, perhaps a patient, is pushing us to do something that we don't feel comfortable doing.

- A common misperception is that the entire act of having a boundary involves telling someone something they can't do or something that they need to do, and expecting them to act in the way you have told them.

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Establishing a Boundary

- Thanks to therapist Lori Gottlieb, who published this advice in the NYT on 1/16/2025!
- Step 1: State the issue + Your desire for maintaining the relationship.
  - “Anna has anorexia and continues to lose weight despite our best treatment. I want to make sure that I continue to provide the best care possible for Anna as her pediatrician.”
- Step 2: Set the boundary
  - “Anna needs a higher level of eating disorder care, and I cannot provide that. I need you to establish care with an eating disorder specialist.”
- Step 3: Hold the boundary
  - When Anna returns to your office 3 months later, having lost more weight, you continue to emphasize that she needs specialist care and that while you can provide for her other pediatric medicine needs, you can no longer offer eating disorder treatment. Anna needs to see an eating disorder specialist.

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What Goes Wrong?

- It should be ***expected*** that, in situations where you feel like you need to set a boundary, ***the person it is being set with will push back.***
- Often, people who are setting the boundary have not actually thought through what it will look like to hold the boundary or they don't follow through on holding the boundary when there is distress.
- We often mischaracterize boundaries as setting a limit about what others can or cannot do. We cannot control others' choices. What we can control is our own choice in how we respond.

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What is a Boundary?

- A boundary is a promise you make to yourself, about how you will behave in a situation.
- You are the person who gets to decide whether you honor the promise you have made to yourself.
- When setting a boundary, we often give the other person some sort of notice, but not always, because we cannot anticipate every situation that will arise.

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Think About What Your Limits Are

- Being able to set a boundary requires you to know your personal limits.
- Sometimes we will encounter a situation that makes us realize or confront a previously unknown limit. That's OK.
- It is normal in medicine to set limits around the scope of your practice based on what you know and understand and can treat effectively. You already do this in many ways.
- As physicians, we are also life-long learners and can learn new information and skills. Doing so may change the boundaries that you set in clinical practice.

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Eating Disorders Levels of Care

- Outpatient Treatment
- IOP (intensive out-patient treatment)
- PHP (partial hospitalization)
- In-Patient
  - Medical stabilization
  - ED program (weight restoration, interruption of ED behaviors, short term care)
- Residential Program

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Outpatient Treatment Team Approach

- Team consists of the young person, family, psychologist, dietician, medical provider
- Psychiatrist medication management
- PCP = medical provider
  - Assess for ED concerns
  - Growth Chart KEY
  - Return visits to ensure no further weight loss and/or weight gain
  - ED complicated illness; status is stable until it's not

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Role of Medical Provider

- Detailed history, physical exam, confidential time with young person
- Gather data (amount of activity, 24-hour dietary recall, avoidance of meals with family, peer interactions, etc.)
- Obtain full set of vital signs
  - Gowned weight, post void
  - BP, pulse, temp
  - Consider orthostatics
- Laboratory screening and EKG to assess safety for outpatient treatment, other etiologies for weight loss

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Medical Provider

- Present the Diagnosis
- Practice being comfortable saying the words, for example, "You meet criteria for Anorexia Nervosa"
- An eating disorder is an illness
- This illness requires Treatment
- If less comfortable managing the illness, please refer to Adolescent Medicine provider to coordinate care

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Medical Provider Role

- Coordination of care
- Assessment of safety (physical and emotional)
- Determine level of care
- Support young person and their family
- Medication management

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Treatment Team: Roles

- **Young person:** recovery = weight restoration, menstrual periods, sports/exercise participation, body image positivity, few to no ED thoughts and behaviors
- **Family:** support, monitoring of eating disorder as an illness, communication with providers
- **Psychologist:** "rewire" the ED thoughts/behaviors (often these are response to stress, anxiety, trauma); improve self-esteem, lessen anxiety and low mood CBT/DBT
- **Dietician:** formulate a meal plan; reintroduce "fear foods", adjust energy input (fuel, calories) as young person becomes hypermetabolic with improved fuel intake

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Family Based Treatment: Maudsley Method

- Evidence based Anorexia Nervosa treatment
- Parents primary caretaker, guidance provided by FBT experienced therapist
- Food preparation, meals/snacks planned by parent
- Parents closely monitor fuel intake, activity
- Phases 1-3
- As adolescent progresses through phases, more independence and intuitive eating with fewer activity restrictions

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IOP

- Typical schedule 3-4 hours/day
- Meet 3-4 Days/week
- Staffed with psychologist, dietician, psychiatrist
- Individual and Group sessions

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PHP

- Similar to IOP, with more time spent in programming
- Daily commitment
- Typical 6-8 hours/day
- Treatment Team
- Individual and Group Sessions
- More support for ED patients

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Inpatient Hospitalization

- Referral from provider to Emergency Room
- Hospital Evaluation
- Admit for medical stability
- Once attained, transfer to In Patient Psychiatric facility and/or PHP/IOP program

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Residential Facility

- Longer term care
- Duration 4-6 months
- Education options available
- Holistic Care
- Art therapy, music, nature, movement
- Group dining (most)
- Supportive safe environment

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Physical Exam Findings

General

- Reduced body fat, reduced muscle mass
- Weight: normal, overweight (OSFED, BN), or underweight
- Hypothermia
- Reduced concentration "brain fog"

Cardiac

- Bradycardia
- Orthostasis
- Hypotension
- EKG changes

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Physical Exam (continued)

Skin

- Lanugo hair
- Acrocyanosis
- Carotenemic palms
- Russels sign

Endocrine

- Pubertal delay or regression
- Breast tissue atrophy

Oral

- Uvular petechiae, dental erosions, parotid gland enlargement

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Lab Evaluation

- **Complete metabolic panel including Mg and Phos**
- Amylase, lipase
- Complete blood count
- TFTs (TSH, free T4, +/- Total T3)
- low T3 indicates malnutrition
- Celiac panel (anti-TTG, total IgA)
- Erythrocyte Sedimentation Rate, CRP
- UA

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PCP Management

- Assessment of Medical and Emotional status
- Obtain vital signs, labs, EKG
- Determine safety for out-patient management vs hospitalization
- Give the diagnosis: Disordered Eating
- Discussion of ED as an illness, helpful for parental understanding
- Frequent follow up visits

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CHP Guidelines for Inpatient Management

- Refer to Local Emergency Room for concerns about medical and/or emotional instability

CHP ER Assessment

- Vital signs
  - Temp < 36
  - BP < 80/50
  - HR < 50 (awake), < 45 (asleep)
  - Orthostasis if symptomatic
- Weight <75%IBW with medical instability
- Electrolyte abnormalities
- Cardiac concerns: syncope, arrhythmia, prolonged QTc
- Other: seizures, hematemesis
- Suicide risk, psychosis

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Levels of Care
Case Presentations

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Ali

- Ali is a 15 y/o referred by Endocrine for primary amenorrhea, weight loss, possible eating disorder.
- Ali had been at 50th%'le (weight/BMI) and fell to 10th%'le.
- "Clean eating" x 2 years, avid athlete. Saw nutritionist in past. Ali's motivation was to start on varsity soccer team ("I have to run faster").
- Per Mom, PCP did not seem concerned about the weight loss or lack of menarche.

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Ali

ROS:

- General: + fatigue
- Resp/CV: neg
- GI: + constipation
- Endocrine: + cold intolerance
- GU: + oligomenorrhea
- Skin: no hair loss, dry skin
- Neuro: no dizziness, syncope, HA
- Psych: + anxiety

Physical Exam:

- General: emaciated teenager
- CV: + bradycardia, + irregular rhythm. + poor perfusion (acrocyanotic hands/feet)
- GI: scaphoid, no tenderness, no masses
- MS: reduced body fat and muscle mass, prominent spinous processes, hip and rib bones
- Skin: + pallor, "sallow"; + extensive lanugo hair
- Psych/Neuro: no focal deficits, no cognitive slowing

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Ali

Vital Signs:

- Supine BP 92/58, P 72
- Standing BP 92/60, P 82
- Body temp 97.9

Lab Evaluation:

- **WBC 4.3 (L)**
- Hgb/Hct = 12.8/37.2
- **ALT 94 (H)**
- AST 22 (normal)
- **ESR = 6, CRP <0.29**
- Neg celiac screening

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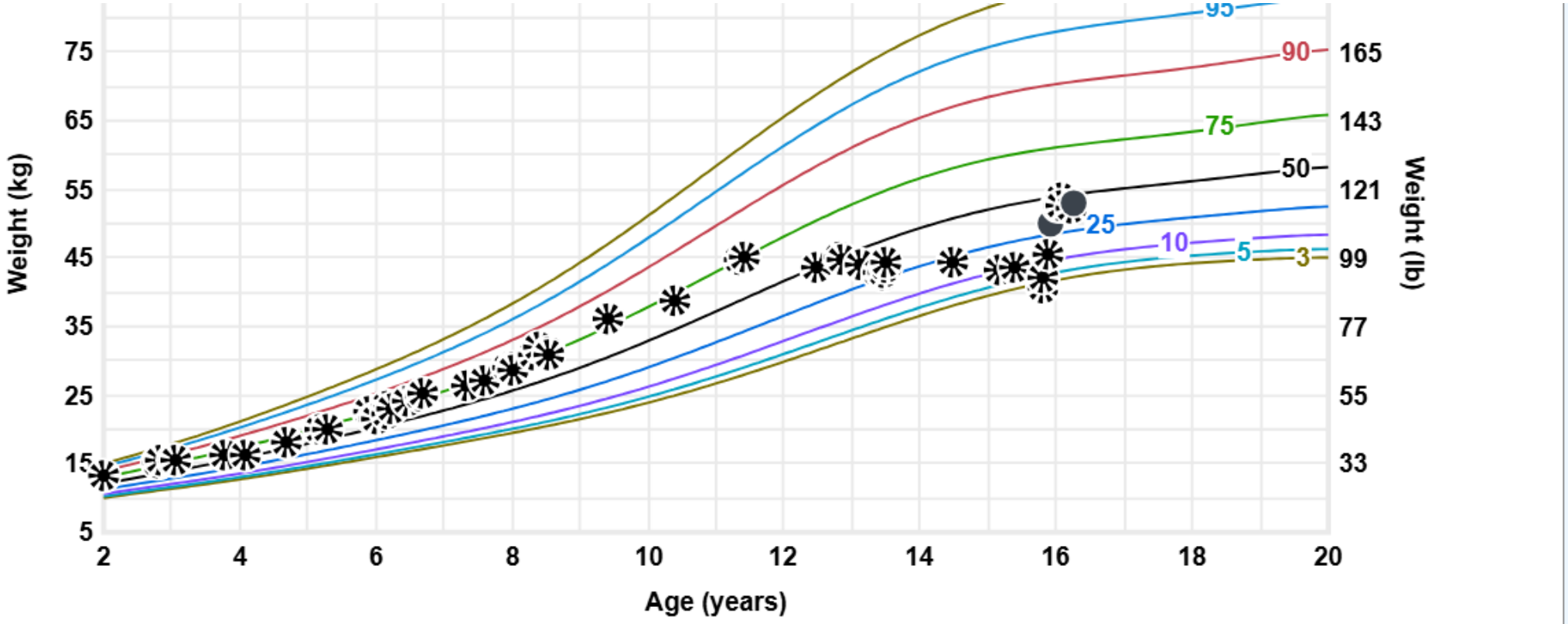
Ali - Weight



Source: Centers for Disease Control and Prevention (CDC). 2000

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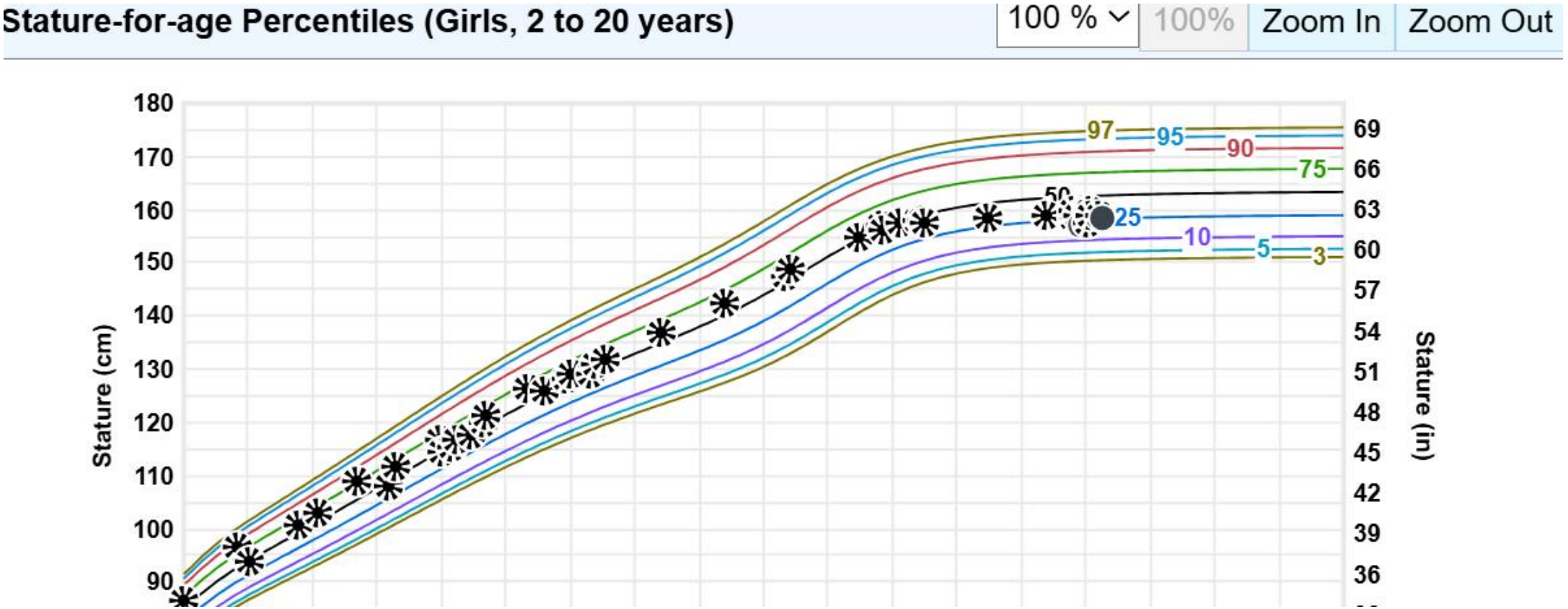
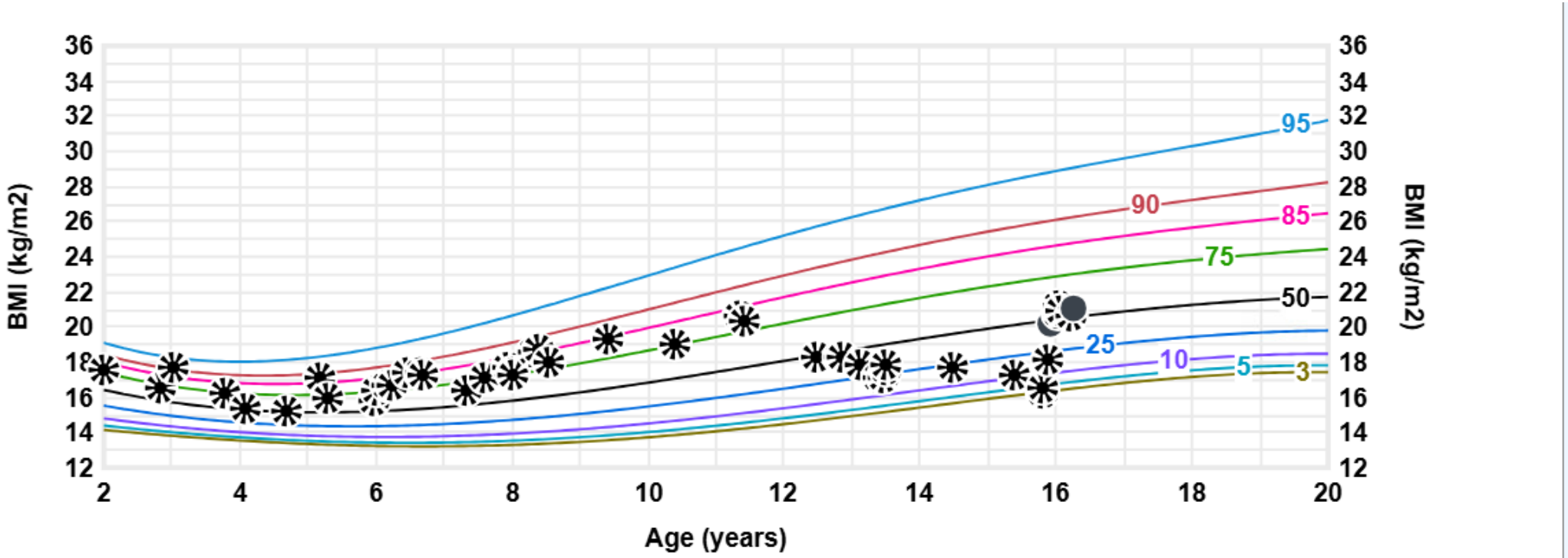
Ali - Height


Stature-for-age Percentiles (Girls, 2 to 20 years)
100 %
100%
Zoom In
Zoom Out
Stature (cm)
180
170
160
150
140
130
120
110
100
90
Stature (in)
69
66
63
60
57
54
51
48
45
42
39
36
97
95
90
75
50
25
10
5
3

Ali - BMI



Source: Centers for Disease Control and Prevention (CDC), 2000

Case 1:
Expert Discussion

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Sarah C.

- Sarah is a 16 y/o presenting for weight loss, anorexia nervosa
- Treatment Team in place
- Weight 75th'le (7/2024) 131 #, now 25th'le (110#), Height 69 " 97th'le
- Restricted fuel intake, daily walks, attempted to purge in past
- Menses: monthly until 2/2024 (> 1 year ago)

- PMhx: GAD, depression

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Sarah C.

ROS:

- General: + lowered appetite, + fatigue
- CV: + chest pain
- GI: + abdominal pain, constipation, post prandial fullness, nausea
- Endo: + cold intolerance, + amenorrhea
- Neuro: + dizziness, - syncope, - HA
- Psych: + decreased concentration ("brain fog")

Physical Exam:

- BP 110/78, PR 57, weight 110 #, BMI 17 kg/m2
- HENT: + dry lips
- CV: PR 56-60 bpm, cold acrocyanotic hands/feet
- GI: soft, nontender; scaphoid; + lanugo hair
- Skin: no pallor, no rash
- Psych: flat affect

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Sarah C.

Labs:

- WBC 3.4 (L)
- Hgb/Hct: 13.4/38.8
- CMP: ALT 37 (H), low Total T3

EKG:

- HR 47 bpm
- Nonspecific T wave abnormality

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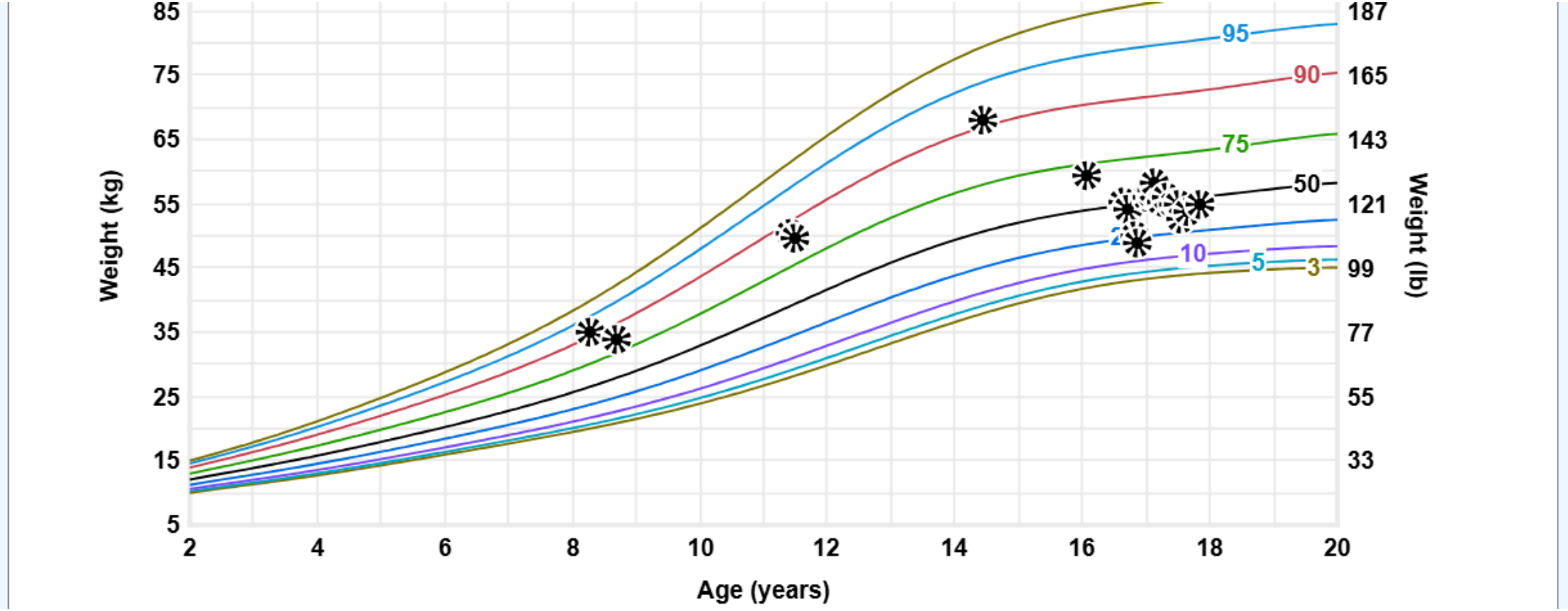
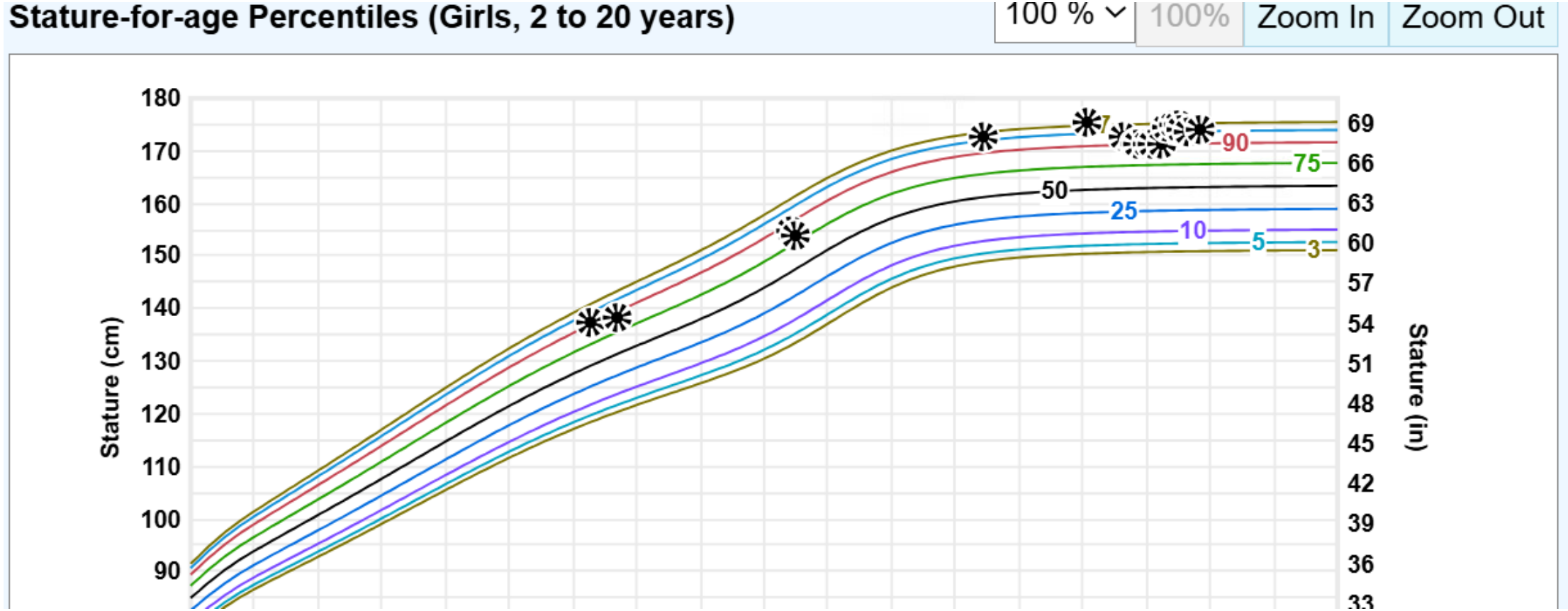
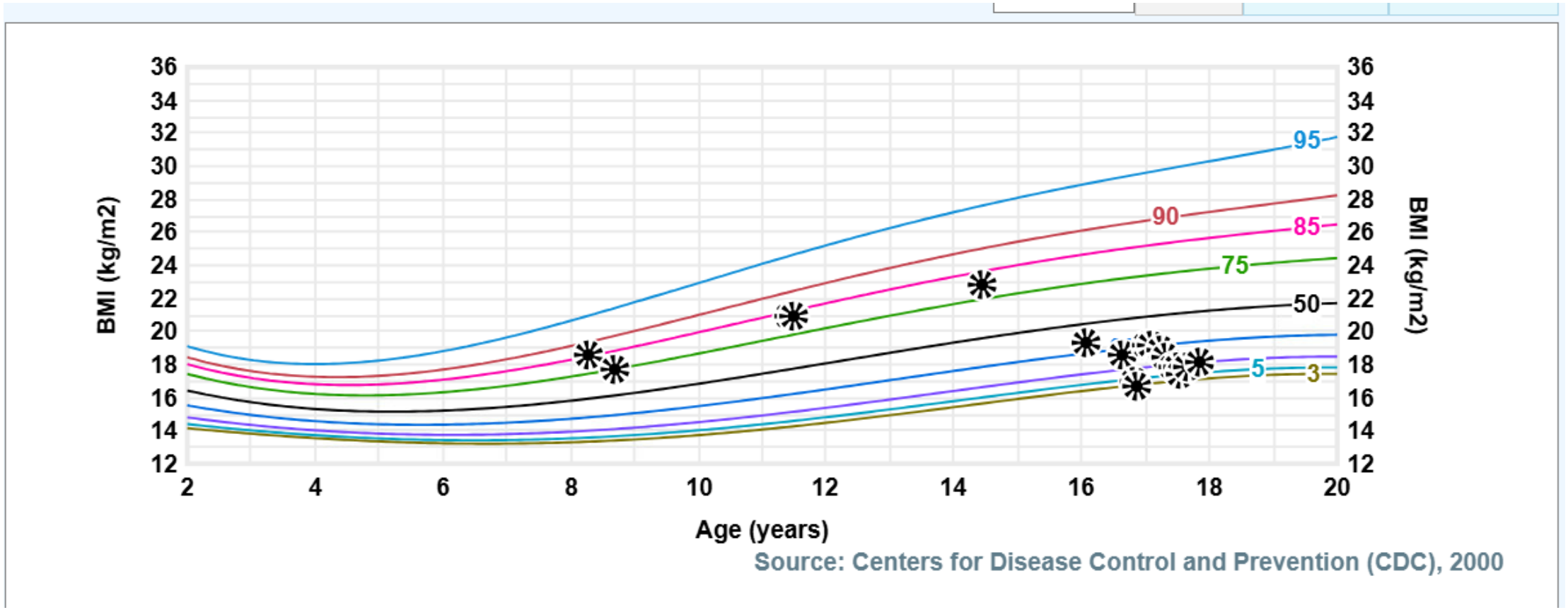
Sarah C. - Weight



Sarah C. - Height



Sarah C. - BMI



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Case 2:
Expert Discussion

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Nick

- Nick is an 18 y/o young man referred for assessment of weight loss.
- His initial visit with me was 11/2024.
- Nick's weight had been > 99th%'le ages 12-18 years with max weight 272 # 10/2023.He was diagnosed with elevated BP and referred to Cardiology, "healthier choices" and "cutting back on food intake" was recommended.
- At the visit 11/2024, his weight had plummeted to 145 # < 50th %'le. He described a very restricted intake, fear of weight gain/fatness, strong dislike of his prior obese habitus, and constant movement.

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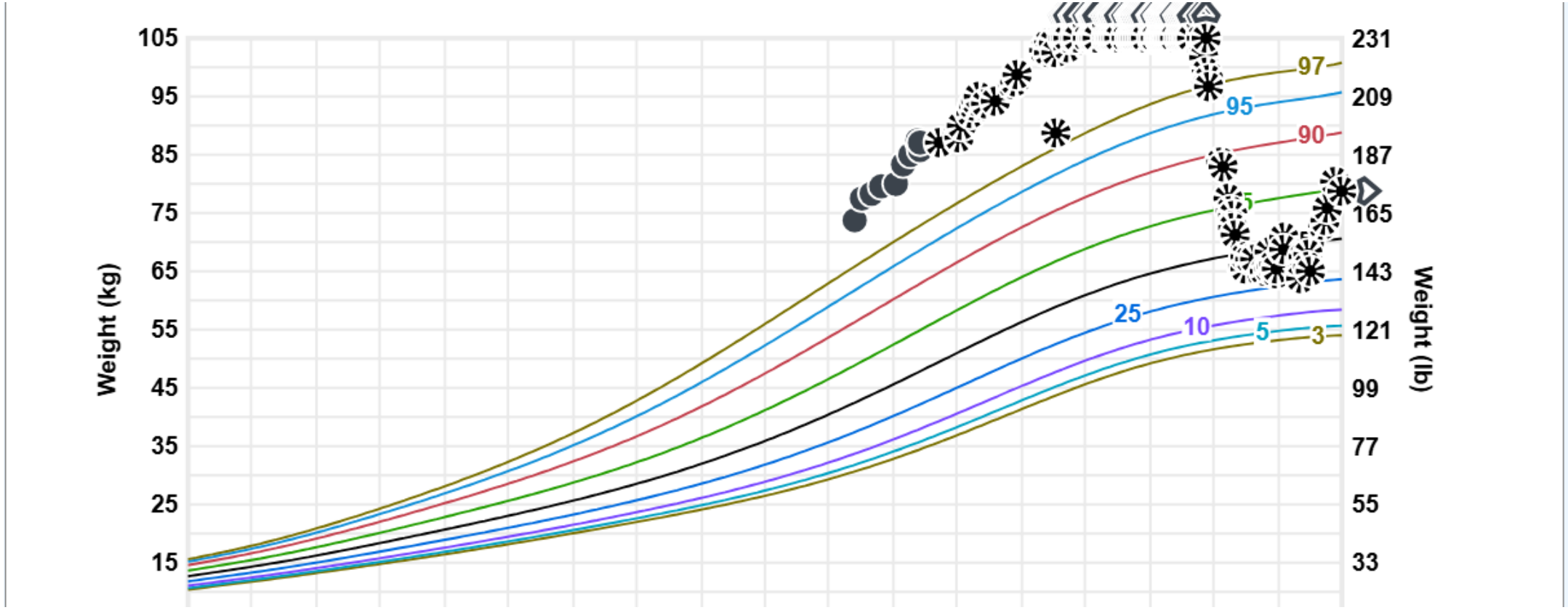
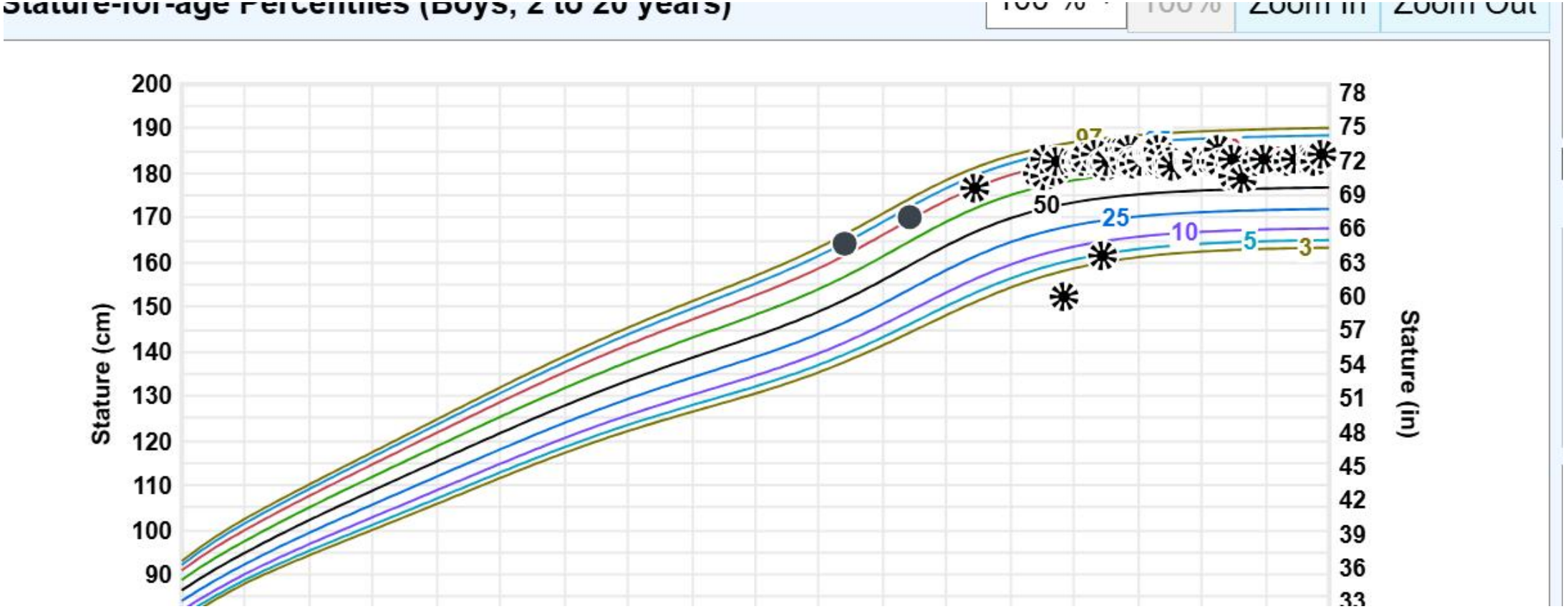
Nick - Weight


Weight (kg)
105
95
85
75
65
55
45
35
25
15
Weight (lb)
231
209
187
165
143
121
99
77
55
33
97
95
90
25
10
5
3

Nick - Height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Stature (cm)
200
190
180
170
160
150
140
130
120
110
100
90
Stature (in)
78
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72
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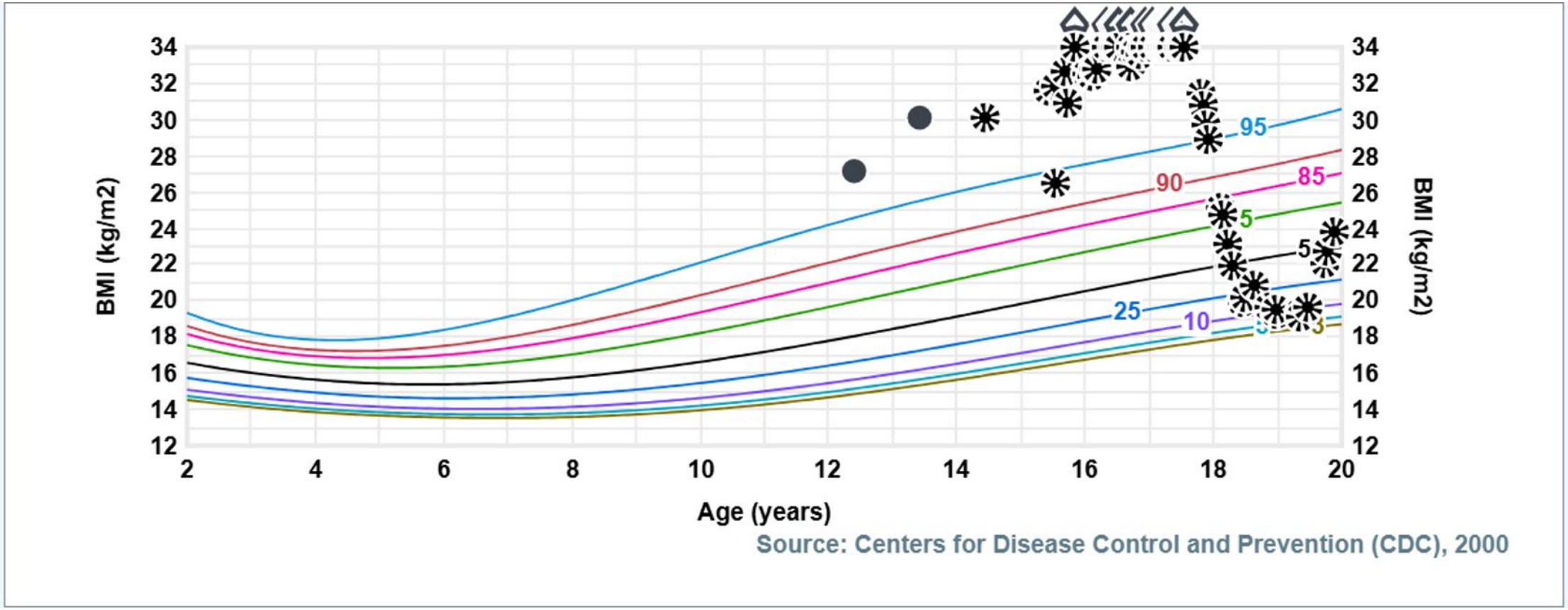
Nick - BMI



Source: Centers for Disease Control and Prevention (CDC), 2000

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Case 3:
Expert Discussion

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Questions?

- Feel free to contact the presenters in the future if needed:
  - Dr. Rebecca Miller: millerrc4@upmc.edu
  - Dr. Elissa Gittes: gitteseb@upmc.edu

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Ask the Experts

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