Treatment of Patients With Eating Disorders

Key Points

Assessment

Treatment
Key Points

➤ The goal of this guideline is to improve the quality of care and treatment outcomes for patients with eating disorders, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR; American Psychiatric Association 2013).

➤ We focus primarily on anorexia nervosa (AN), bulimia nervosa (BN), and binge-eating disorder (BED) rather than other feeding and eating disorders.

➤ The lifetime prevalence of eating disorders in the United States is approximately 0.80% for AN, 0.28% for BN, and 0.85% for BED.

➤ The lifetime burdens and psychosocial impairments associated with an eating disorder can be substantial because these illnesses typically have an onset in adolescence or early adulthood and can persist for decades.

➤ Eating disorders are associated with increases in all-cause mortality and deaths due to suicide.

➤ Morbidity and mortality among individuals with an eating disorder are heightened by the common co-occurrence of health conditions, such as diabetes, and other psychiatric disorders, particularly depression, anxiety, posttraumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), attention-deficit/hyperactivity disorder (ADHD), and substance use disorders.

➤ This guideline is intended to enhance the assessment and treatment of eating disorders, thereby reducing the mortality, morbidity, and significant psychosocial and health consequences of these important psychiatric conditions.
Table 1. Grading Recommendations

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em>Recommendation</em>: indicates confidence that the benefits of the intervention clearly outweigh harms.</td>
</tr>
<tr>
<td>2</td>
<td><em>Suggestion</em>: indicates greater uncertainty; although the benefits of the statement are still viewed as outweighing the harms, balance of benefits and harms is more difficult to judge, or the benefits or the harms may be less clear. With a suggestion, patient values and preferences may be more variable, and this can influence the clinical decision that is ultimately made.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade</th>
<th>Strength of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td><em>High</em>: high confidence that the evidence reflects the true effect. Further research is very unlikely to change our confidence in the estimate of effect.</td>
</tr>
<tr>
<td>B</td>
<td><em>Moderate</em>: moderate confidence that the evidence reflects the true effect. Further research may change our confidence in the estimate of effect and may change the estimate.</td>
</tr>
<tr>
<td>C</td>
<td><em>Low</em>: low confidence that the evidence reflects the true effect. Further research is likely to change our confidence in the estimate of effect and is likely to change the estimate.</td>
</tr>
</tbody>
</table>
### Screening for Presence of an Eating Disorder

**Statement 1**

- APA recommends (1C) screening for the presence of an eating disorder as part of an initial psychiatric evaluation.

### Table 2. Screening Questionnaires for Eating Disorders

(Instructions: circle “Y” for “yes” and “N” for “no”)

#### SCOFF Questionnaire (Morgan et al. 1999)

<table>
<thead>
<tr>
<th>Y / N</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y / N</td>
<td>Do you make yourself <strong>sick</strong> because you feel uncomfortably full?</td>
</tr>
<tr>
<td>Y / N</td>
<td>Do you worry you have lost <strong>control</strong> over how much you eat?</td>
</tr>
<tr>
<td>Y / N</td>
<td>Have you recently lost &gt;14 lbs (<strong>one stone</strong>) in a 3-month period?</td>
</tr>
<tr>
<td>Y / N</td>
<td>Do you believe yourself to be <strong>fat</strong> when others say you are too thin?</td>
</tr>
<tr>
<td>Y / N</td>
<td>Would you say that <strong>food</strong> dominates your life?</td>
</tr>
<tr>
<td>Y / N</td>
<td><strong>To assess for binge-eating disorder, add:</strong> During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?</td>
</tr>
</tbody>
</table>

#### Screen for Disordered Eating (Maguen et al. 2018)

<table>
<thead>
<tr>
<th>Y / N</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y / N</td>
<td>Do you often feel the desire to eat when you are emotionally upset or stressed?</td>
</tr>
<tr>
<td>Y / N</td>
<td>Do you often feel that you can’t control what or how much you eat?</td>
</tr>
<tr>
<td>Y / N</td>
<td>Do you sometimes make yourself throw up (vomit) to control your weight?</td>
</tr>
<tr>
<td>Y / N</td>
<td>Are you often preoccupied with a desire to be thinner?</td>
</tr>
<tr>
<td>Y / N</td>
<td>Do you believe yourself to be fat when others say you are too thin?</td>
</tr>
</tbody>
</table>

#### Eating Disorder Screen for Primary Care (Cotton et al. 2003)

<table>
<thead>
<tr>
<th>Y / N</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y / N</td>
<td>Are you satisfied with your eating patterns? Answering “no” to this question is classified as an abnormal response.</td>
</tr>
<tr>
<td>Y / N</td>
<td>Do you ever eat in secret? Answering “yes” to this and all other questions is classified as an abnormal response.</td>
</tr>
<tr>
<td>Y / N</td>
<td>Does your weight affect the way you feel about yourself?</td>
</tr>
<tr>
<td>Y / N</td>
<td>Have any members of your family suffered with an eating disorder?</td>
</tr>
<tr>
<td>Y / N</td>
<td>Do you make yourself sick because you feel uncomfortably full?</td>
</tr>
</tbody>
</table>
Initial Evaluation of Eating History

**Statement 2**

➤ APA recommends (1C) that the initial evaluation of a patient with a possible eating disorder include assessment of:

• the patient’s height and weight history (e.g., maximum and minimum weight, recent weight changes);

• presence of, patterns in, and changes in restrictive eating, food avoidance, binge eating, and other eating-related behaviors (e.g., rumination, regurgitation, chewing and spitting);

• patterns and changes in food repertoire (e.g., breadth of food variety, narrowing or elimination of food groups);

• presence of, patterns in, and changes in compensatory and other weight control behaviors, including dietary restriction, compulsive or driven exercise, purging behaviors (e.g., laxative use, self-induced vomiting), and use of medication to manipulate weight;

• percentage of time preoccupied with food, weight, and body shape;

• prior treatment and response to treatment for an eating disorder;

• psychosocial impairment secondary to eating or body image concerns or behaviors; and

• family history of eating disorders, other psychiatric illnesses, and other medical conditions (e.g., obesity, inflammatory bowel disease, diabetes mellitus).

Quantitative Measures

**Statement 3**

➤ APA recommends (1C) that the initial psychiatric evaluation of a patient with a possible eating disorder include weighing the patient and quantifying eating and weight control behaviors (e.g., frequency, intensity, or time spent on dietary restriction, binge eating, purging, exercise, and other compensatory behaviors).

Identification of Co-Occurring Conditions

**Statement 4**

➤ APA recommends (1C) that the initial psychiatric evaluation of a patient with a possible eating disorder identify co-occurring health conditions, including co-occurring psychiatric disorders.
**Statement 5**

APA recommends (1C) that the initial psychiatric evaluation of a patient with a possible eating disorder include a comprehensive review of systems.

### Table 3. Signs and Symptoms of Eating Disorders

<table>
<thead>
<tr>
<th>Organ System</th>
<th>Symptom/Sign¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Related to nutritional restriction</td>
</tr>
<tr>
<td>General</td>
<td>Low weight, cachexia</td>
</tr>
<tr>
<td>General</td>
<td>Fatigue</td>
</tr>
<tr>
<td>General</td>
<td>Weakness</td>
</tr>
<tr>
<td>General</td>
<td>Dehydration</td>
</tr>
<tr>
<td>General</td>
<td>Cold intolerance, low body temperature</td>
</tr>
<tr>
<td>General</td>
<td>Hot flashes, sweating</td>
</tr>
<tr>
<td>Nervous system</td>
<td>Anxiety, depression, or irritability</td>
</tr>
<tr>
<td>Nervous system</td>
<td>Apathy</td>
</tr>
<tr>
<td>Nervous system</td>
<td>Poor concentration</td>
</tr>
<tr>
<td>Nervous system</td>
<td>Headache</td>
</tr>
<tr>
<td>Nervous system</td>
<td>Seizures (in severe cases)</td>
</tr>
<tr>
<td>Nervous system</td>
<td>Peripheral polyneuropathy (in severe cases)</td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td>Dysphagia</td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td>Dental enamel erosion and decay</td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td>Enlarged salivary glands</td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td>Pharyngeal pain</td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td>Palatal scratches, erythema, or petechiae</td>
</tr>
<tr>
<td>Organ System</td>
<td>Symptom/Sign</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Abdominal discomfort</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Constipation</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Nausea</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Early satiety</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Abdominal distention, bloating</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Dizziness, faintness, orthostatic hypotension</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Palpitations, arrhythmias</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Bradycardia</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Weak irregular pulse</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Cold extremities, acrocyanosis</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Chest pain</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Dyspnea</td>
</tr>
<tr>
<td>Reproductive/Endocrine</td>
<td>Slowing of growth (in children or adolescents)</td>
</tr>
<tr>
<td>Reproductive/Endocrine</td>
<td>Arrested development of secondary sex characteristics</td>
</tr>
<tr>
<td>Reproductive/Endocrine</td>
<td>Low libido</td>
</tr>
<tr>
<td>Reproductive/Endocrine</td>
<td>Fertility problems</td>
</tr>
<tr>
<td>Reproductive/Endocrine</td>
<td>Oligomenorrhea</td>
</tr>
<tr>
<td>Reproductive/Endocrine</td>
<td>Primary or secondary amenorrhea</td>
</tr>
</tbody>
</table>
## Table 3. Signs and Symptoms of Eating Disorders (cont’d)

<table>
<thead>
<tr>
<th>Organ System</th>
<th>Symptom/Sign¹</th>
<th>Related to nutritional restriction</th>
<th>Related to purging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal</td>
<td>Proximal muscle weakness, wasting, or atrophy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Muscle cramping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Bone pain²</td>
<td></td>
<td>Bone pain²</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Stress fractures²</td>
<td></td>
<td>Stress fractures²</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Slowed growth (relative to expected)²</td>
<td></td>
<td>Slowed growth (relative to expected)²</td>
</tr>
<tr>
<td>Dermatological</td>
<td>Dry, yellow skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatological</td>
<td>Change in hair including hair loss and dry and brittle hair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatological</td>
<td>Lanugo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatological</td>
<td>Scarring on dorsum of hand (Russell’s sign)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatological</td>
<td>Poor skin turgor</td>
<td></td>
<td>Poor skin turgor</td>
</tr>
<tr>
<td>Dermatological</td>
<td>Pitting edema (with refeeding)</td>
<td></td>
<td>Pitting edema</td>
</tr>
</tbody>
</table>

¹ Symptoms are in regular font; signs are in italic font.
² Risk of skeletal effects is in individuals with previous low weight and menstrual irregularity or amenorrhea.
**Initial Physical Examination**

**Statement 6**

➤ APA recommends (1C) that the initial physical examination of a patient with a possible eating disorder include assessment of vital signs, including temperature, resting heart rate, blood pressure, orthostatic pulse, and orthostatic blood pressure; height, weight, and body mass index (BMI) (or percent median BMI, BMI percentile, or BMI Z-score for children and adolescents); and physical appearance, including signs of malnutrition or purging behaviors.

**Initial Laboratory Assessment**

**Statement 7**

➤ APA recommends (1C) that the laboratory assessment of a patient with a possible eating disorder include a complete blood count and a comprehensive metabolic panel, including electrolytes, liver enzymes, and renal function tests.
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Organ system</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended</td>
<td>Cardiovascular</td>
<td>ECG</td>
</tr>
<tr>
<td>Recommended</td>
<td>Metabolic</td>
<td>Serum electrolytes</td>
</tr>
<tr>
<td>Recommended</td>
<td>Gastrointestinal</td>
<td>Liver function and associated tests</td>
</tr>
<tr>
<td>Recommended</td>
<td>Genitourinary</td>
<td>Renal function tests</td>
</tr>
<tr>
<td>Based on history or exam</td>
<td>Genitourinary</td>
<td>Urinalysis</td>
</tr>
<tr>
<td>Based on history or exam</td>
<td>Reproductive</td>
<td>Serum gonadotropins and sex hormones</td>
</tr>
<tr>
<td>Based on history or exam</td>
<td>Skeletal</td>
<td>Bone densitometry (DXA scan)</td>
</tr>
<tr>
<td>Incidental</td>
<td>Oropharyngeal</td>
<td>Dental radiography</td>
</tr>
</tbody>
</table>

Abbreviations: BMD=bone mineral density; BUN=blood urea nitrogen; Cr=creatinine; DXA=dual-energy X-ray absorptiometry; ECG=electrocardiogram; GFR=glomerular filtration rate; QTc=corrected QT interval
## Table 4. Laboratory Abnormalities Related to Nutritional Restriction or Purging Behaviors

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Organ system</th>
<th>Test</th>
<th>Related to nutritional restriction</th>
<th>Related to purging</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>ECG</td>
<td>Bradycardia or arrhythmias, QTc prolongation</td>
<td>Increased P-wave amplitude and duration, increased PR interval, widened QRS complex, QTc prolongation, ST depression, T-wave inversion or flattening, U waves, supraventricular or ventricular tachyarrhythmias</td>
</tr>
<tr>
<td></td>
<td>Metabolic</td>
<td>Serum electrolytes</td>
<td>Hypokalemia, hyponatremia, hypomagnesemia, hypophosphatemia (especially on refeeding)</td>
<td>Hypokalemia, hyponatremia, hypochloremia, hypomagnesemia, hypophosphatemia, metabolic acidosis</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal</td>
<td>Liver function and associated tests</td>
<td>Elevated liver function tests</td>
<td>Increased BUN, decreased GFR, decreased Cr because of low lean body mass (normal Cr may indicate azotemia), renal failure (rare)</td>
</tr>
<tr>
<td>Low blood sugar</td>
<td>Genitourinary</td>
<td>Renal function tests</td>
<td>Increased BUN and Cr, renal failure (rare)</td>
<td>Increased BUN and Cr, renal failure (rare)</td>
</tr>
<tr>
<td></td>
<td>Reproductive</td>
<td>Serum gonadotropins and sex hormones</td>
<td>May be hypoestrogenemic if menstrual irregularities are present</td>
<td>May be hypoestrogenemic if menstrual irregularities are present</td>
</tr>
<tr>
<td></td>
<td>Skeletal</td>
<td>Bone densitometry (DXA scan)</td>
<td>Reduced BMD, osteopenia, or osteoporosis in individuals with previous low weight and menstrual irregularity or amenorrhea</td>
<td>Reduced BMD, osteopenia or osteoporosis in individuals with previous low weight and menstrual irregularity or amenorrhea</td>
</tr>
<tr>
<td></td>
<td>Incidental</td>
<td>Oropharyngeal</td>
<td>Erosion of dental enamel</td>
<td>Erosion of dental enamel</td>
</tr>
</tbody>
</table>

Abbreviations: BMD=bone mineral density; BUN=blood urea nitrogen; Cr=creatinine; DXA=dual-energy X-ray absorptiometry; ECG=electrocardiogram; GFR=glomerular filtration rate; QTc=corrected QT interval.
Assessment

Initial Electrocardiogram

Statement 8
➤ APA recommends (1C) that an electrocardiogram be done in patients with a restrictive eating disorder, patients with severe purging behavior, and patients who are taking medications that are known to prolong QTc intervals.

Treatment Plan, Including Level of Care

Statement 9
➤ APA recommends (1C) that patients with an eating disorder have a documented, comprehensive, culturally appropriate, and person-centered treatment plan that incorporates medical, psychiatric, psychological, and nutritional expertise, commonly via a coordinated multidisciplinary team.
<table>
<thead>
<tr>
<th>Table 5. Considerations in Determining an Appropriate Level of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Factors that suggest significant medical instability, which may require hospitalization for acute medical stabilization, including need for monitoring, fluid management (including intravenous fluids), electrolyte replacement, or nutritional supplementation via nasogastric tube feeding (see Table 6)</td>
</tr>
<tr>
<td>• Factors that suggest a need for inpatient psychiatric treatment (e.g., significant suicide risk, aggressive behaviors, impaired safety due to psychosis/self-harm, need for treatment over objection or involuntary treatment)</td>
</tr>
<tr>
<td>• Co-occurring conditions (e.g., diabetes, substance use disorders) that would significantly affect treatment needs and require a higher level of care.</td>
</tr>
<tr>
<td>• Lack of response or deterioration in patient’s condition in individuals receiving outpatient treatment</td>
</tr>
<tr>
<td>• Extent to which the patient is able to decrease or stop eating disorder and weight control behaviors (e.g., dietary restriction, binge eating, purging, excessive exercise) without meal support or monitoring</td>
</tr>
<tr>
<td>• Level of motivation to recover, including insight, cooperation with treatment, and willingness to engage in behavior change</td>
</tr>
<tr>
<td>• Psychosocial context, including level of environmental and psychosocial stress and ability to access support systems</td>
</tr>
<tr>
<td>• Extent to which a patient’s access to a level of care is influenced by logistical factors (e.g., geographical considerations; financial or insurance considerations; access to transportation or housing; school, work, or childcare needs)</td>
</tr>
</tbody>
</table>
Table 6. Factors Supporting Medical Hospitalization or Hospitalization on a Specialized Eating Disorder Unit

<table>
<thead>
<tr>
<th>Factor</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart rate</td>
<td>&lt;50 bpm</td>
</tr>
<tr>
<td>Orthostatic change in heart rate</td>
<td>Sustained increase of &gt;30 bpm</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>&lt;90/60 mmHg</td>
</tr>
<tr>
<td>Orthostatic blood pressure</td>
<td>&gt;20 mmHg drop in sBP</td>
</tr>
<tr>
<td>Glucose</td>
<td>&lt;60 mg/dL</td>
</tr>
<tr>
<td>Potassium</td>
<td>Hypokalemia(^1)</td>
</tr>
<tr>
<td>Sodium</td>
<td>Hyponatremia(^1)</td>
</tr>
<tr>
<td>Phosphate</td>
<td>Hypophosphatemia(^1)</td>
</tr>
<tr>
<td>Magnesium</td>
<td>Hypomagnesemia(^1)</td>
</tr>
<tr>
<td>Temperature</td>
<td>&lt;36° C (&lt;96.8° F)</td>
</tr>
<tr>
<td>BMI</td>
<td>&lt;15</td>
</tr>
<tr>
<td>Rapidity of weight change</td>
<td>&gt;10% weight loss in 6 months or &gt;20% weight loss in 1 year</td>
</tr>
<tr>
<td>Compensatory behaviors</td>
<td>Occur frequently and have either caused serious physiological consequences or not responded to treatment at a lower level of care</td>
</tr>
<tr>
<td>ECG</td>
<td>Prolonged QTc &gt;450 or other significant ECG abnormalities</td>
</tr>
<tr>
<td>Other conditions</td>
<td>Acute medical complications of malnutrition (e.g., seizures, syncope, cardiac failure, pancreatitis)</td>
</tr>
</tbody>
</table>

\(^1\) Reference ranges for potassium, sodium, phosphate, and magnesium and numerical thresholds for values that determine hypokalemia, hyponatremia, hypophosphatemia, and hypomagnesemia depend upon the clinical laboratory.

Abbreviations: BMI=body mass index; bpm=beats per minute; ECG=electrocardiogram; mmHg=mm mercury; QTc=corrected QT interval; sBP=systolic blood pressure
<table>
<thead>
<tr>
<th>Factor</th>
<th>Adults</th>
<th>Adolescents (12–19 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart rate</td>
<td>&lt;50 bpm</td>
<td>&lt;50 bpm</td>
</tr>
<tr>
<td>Orthostatic change in heart rate</td>
<td></td>
<td>Sustained increase of &gt;40 bpm</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>&lt;90/60 mmHg</td>
<td>&lt;90/45 mmHg</td>
</tr>
<tr>
<td>Orthostatic blood pressure</td>
<td></td>
<td>&gt;20 mmHg drop in sBP</td>
</tr>
<tr>
<td>Glucose</td>
<td>&lt;60 mg/dL</td>
<td>&lt;60 mg/dL</td>
</tr>
<tr>
<td>Potassium</td>
<td></td>
<td>Hypokalemia1</td>
</tr>
<tr>
<td>Sodium</td>
<td></td>
<td>Hyponatremia1</td>
</tr>
<tr>
<td>Phosphate</td>
<td></td>
<td>Hypophosphatemia1</td>
</tr>
<tr>
<td>Magnesium</td>
<td></td>
<td>Hypomagnesemia1</td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
<td>&lt;36° C (&lt;96.8° F)</td>
</tr>
<tr>
<td>BMI</td>
<td>&lt;15</td>
<td>&lt;75% of median BMI for age and sex</td>
</tr>
<tr>
<td>Rapidity of weight change</td>
<td></td>
<td>&gt;10% weight loss in 6 months or &gt;20% weight loss in 1 year</td>
</tr>
<tr>
<td>Compensatory behaviors</td>
<td></td>
<td>Occur frequently and have either caused serious physiological consequences or not responded to treatment at a lower level of care</td>
</tr>
<tr>
<td>ECG</td>
<td></td>
<td>Prolonged QTc &gt;450 or other significant ECG abnormalities</td>
</tr>
<tr>
<td>Other conditions</td>
<td></td>
<td>Acute medical complications of malnutrition (e.g., seizures, syncope, cardiac failure, pancreatitis), arrested growth and development</td>
</tr>
</tbody>
</table>

Abbreviations: BMI = body mass index; bpm = beats per minute; ECG = electrocardiogram; mmHg = mm mercury; QTc = corrected QT interval; sBP = systolic blood pressure
### Table 7. Characteristics of Levels of Care

<table>
<thead>
<tr>
<th>Level of care</th>
<th>Specialized pediatric/medical inpatient eating disorders program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit security</td>
<td>Unlocked</td>
</tr>
<tr>
<td>Patient legal status</td>
<td>Voluntary or involuntary</td>
</tr>
<tr>
<td>Physician on-site 24/7</td>
<td>On-site 24/7</td>
</tr>
<tr>
<td>Nursing on-site 24/7</td>
<td>On-site 24/7</td>
</tr>
<tr>
<td>Medical monitoring</td>
<td>Frequent</td>
</tr>
<tr>
<td>Hours of operation</td>
<td>24/7</td>
</tr>
<tr>
<td>Able to maintain work/school</td>
<td>School, in some instances</td>
</tr>
</tbody>
</table>

### Available interventions

<table>
<thead>
<tr>
<th>Available interventions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Option for IV hydration</td>
<td>Yes</td>
</tr>
<tr>
<td>Option for nasogastric tube feedings</td>
<td>Yes</td>
</tr>
<tr>
<td>Option for treatment over objection</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical management</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychiatric management</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychological management</td>
<td>Yes</td>
</tr>
<tr>
<td>Group-based therapies</td>
<td>Yes</td>
</tr>
<tr>
<td>Individual psychotherapies</td>
<td>Yes</td>
</tr>
<tr>
<td>Family psychotherapies</td>
<td>Yes</td>
</tr>
<tr>
<td>Meal supervision and support</td>
<td>All meals/day</td>
</tr>
<tr>
<td>Milieu therapy</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional management</td>
<td>Yes</td>
</tr>
<tr>
<td>Multi-disciplinary team-based management</td>
<td>Yes</td>
</tr>
<tr>
<td>General pediatric/medical inpatient program</td>
<td>Specialized psychiatric inpatient eating disorders program</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Unlocked</td>
<td>Typically locked</td>
</tr>
<tr>
<td>Voluntary</td>
<td>Voluntary or involuntary</td>
</tr>
<tr>
<td>On-site 24/7</td>
<td>On-call or on-site 24/7</td>
</tr>
<tr>
<td>On-site 24/7</td>
<td>On-site 24/7</td>
</tr>
<tr>
<td>Frequent</td>
<td>Frequent</td>
</tr>
<tr>
<td>24/7</td>
<td>24/7</td>
</tr>
<tr>
<td>School, in some instances</td>
<td>School, in some instances</td>
</tr>
<tr>
<td>Yes</td>
<td>On some units</td>
</tr>
<tr>
<td>Yes</td>
<td>On some units</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>Consultation</td>
</tr>
<tr>
<td>Consultation</td>
<td>Yes</td>
</tr>
<tr>
<td>In some instances</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Generally not available</td>
<td>Yes</td>
</tr>
<tr>
<td>Generally not available</td>
<td>On some units</td>
</tr>
<tr>
<td>In some instances</td>
<td>All meals/day</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Consultation</td>
<td>Yes</td>
</tr>
<tr>
<td>In some instances, not eating disorder specific</td>
<td>Yes</td>
</tr>
<tr>
<td>Level of care</td>
<td>Residential program</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Unit security</td>
<td>Unlocked</td>
</tr>
<tr>
<td>Patient legal status</td>
<td>Voluntary</td>
</tr>
<tr>
<td>Physician on-site 24/7</td>
<td>On-call 24/7</td>
</tr>
<tr>
<td>Nursing on-site 24/7</td>
<td>Typically on-site 24/7</td>
</tr>
<tr>
<td>Medical monitoring</td>
<td>Limited</td>
</tr>
<tr>
<td>Hours of operation</td>
<td>24/7</td>
</tr>
<tr>
<td>Able to maintain work/school</td>
<td>School, in some instances</td>
</tr>
</tbody>
</table>

### Available interventions

<table>
<thead>
<tr>
<th>Available interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option for IV hydration</td>
</tr>
<tr>
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</tr>
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<td>Option for treatment over objection</td>
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<td>Group-based therapies</td>
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<td>Individual psychotherapies</td>
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<tr>
<td>Family psychotherapies</td>
</tr>
<tr>
<td>Meal supervision and support</td>
</tr>
<tr>
<td>Milieu therapy</td>
</tr>
<tr>
<td>Nutritional management</td>
</tr>
<tr>
<td>Multi-disciplinary team-based management</td>
</tr>
<tr>
<td>Partial hospital</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Unlocked</td>
</tr>
<tr>
<td>Voluntary</td>
</tr>
<tr>
<td>Typically not on-site full-time</td>
</tr>
<tr>
<td>Typically not on-site full-time</td>
</tr>
<tr>
<td>Limited</td>
</tr>
<tr>
<td>Variable hours per day (5–12 hours) and days per week (5–7)</td>
</tr>
<tr>
<td>School, in some instances</td>
</tr>
</tbody>
</table>

| No | No | No |
| No | No | No |
| No | No | No |
| No | No | No |
| Limited consultation | No | Outpatient, as indicated |
| Yes | Variable | As indicated |
| Yes | Yes | Yes |
| Yes | Yes | As indicated |
| Yes | Yes | Yes |
| Yes | Yes | Yes |
| Yes | Yes | Yes |
| Yes | Yes | Yes |
| Yes | Yes | Yes |
| 2–3 meals/day | ~1 meal/day | Provided by family or care partners |
| Yes | Yes | No |
| Yes | Variable | As indicated |
| Yes | Yes | As indicated |
ANOREXIA NERVOSA

Medical Stabilization, Nutritional Rehabilitation, and Weight Restoration

**Statement 10**

➤ APA recommends (1C) that patients with anorexia nervosa who require nutritional rehabilitation and weight restoration have individualized goals set for weekly weight gain and target weight.

Psychotherapy in Adults

**Statement 11**

➤ APA recommends (1B) that adults with anorexia nervosa be treated with an eating disorder-focused psychotherapy, which should include normalizing eating and weight control behaviors, restoring weight, and addressing psychological aspects of the disorder (e.g., fear of weight gain, body image disturbance).

Table 8. Components of Psychotherapies for the Treatment of Anorexia Nervosa

<table>
<thead>
<tr>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-session weighing</td>
</tr>
<tr>
<td>Individualized case formulation</td>
</tr>
<tr>
<td>Motivational phase of treatment</td>
</tr>
<tr>
<td>Focus on interpersonal issues/emotional expression</td>
</tr>
<tr>
<td>Monitoring of symptoms, including eating</td>
</tr>
<tr>
<td>Examining association of symptoms/eating with cognitions</td>
</tr>
<tr>
<td>Focus on building activities/passions to minimize overconcern with weight/body shape</td>
</tr>
<tr>
<td>Use of an experimental mindset to change attitudes and behaviors</td>
</tr>
<tr>
<td>Parent-facilitated meal supervision</td>
</tr>
</tbody>
</table>

Abbreviations: AFT=adolescent focused individual therapy; CBT-AN=cognitive-behavioral therapy for anorexia nervosa; CBT-E=enhanced cognitive-behavioral therapy for eating disorders; ECHO=Experienced Carers Helping Others; FBT=family-based therapy/treatment; FPT=focal psychodynamic psychotherapy; MANTRA=Maudsley Model of Anorexia Nervosa Treatment for Adults; SSCM=Specialist Supportive Clinical Management
Family-Based Treatment in Adolescents and Emerging Adults

**Statement 12**

- APA recommends (1B) that adolescents and emerging adults with anorexia nervosa who have an involved caregiver be treated with eating disorder-focused family-based treatment, which should include caregiver education aimed at normalizing eating and weight control behaviors and restoring weight.

<table>
<thead>
<tr>
<th>CBT-AN</th>
<th>CBT-E</th>
<th>FPT</th>
<th>SSCM</th>
<th>MANTRA</th>
<th>ECHO</th>
<th>AFT</th>
<th>FBT</th>
</tr>
</thead>
<tbody>
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<td>×</td>
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<td>x</td>
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BULIMIA NERVOSA

Cognitive-Behavioral Therapy and Serotonin Reuptake Inhibitor Treatment for Adults

Statement 13
➤ APA recommends (1C) that adults with bulimia nervosa be treated with eating disorder-focused cognitive-behavioral therapy and that a serotonin reuptake inhibitor (e.g., 60 mg fluoxetine daily) also be prescribed, either initially or if there is minimal or no response to psychotherapy alone by 6 weeks of treatment.

Family-Based Treatment in Adolescents and Emerging Adults

Statement 14
➤ APA suggests (2C) that adolescents and emerging adults with bulimia nervosa who have an involved caregiver be treated with eating disorder-focused family-based treatment.
BINGE-EATING DISORDER

Psychotherapy

Statement 15
➤ APA recommends (1C) that patients with binge-eating disorder be treated with eating disorder-focused cognitive-behavioral therapy or interpersonal therapy, in either individual or group formats.

Medications in Adults

Statement 16
➤ APA suggests (2C) that adults with binge-eating disorder who prefer medication or have not responded to psychotherapy alone be treated with either an antidepressant medication or lisdexamfetamine.
Abbreviations
ADHD, attention-deficit/hyperactivity disorder; AFT, adolescent focused individual therapy; AN, anorexia nervosa; APA, American Psychiatric Association; BED, binge-eating disorder; BMD, bone mineral density; BMI, body mass index; BN, bulimia nervosa; bpm, beats per minute; BUN, blood urea nitrogen; CBT, cognitive-behavioral therapy; CBT-AN, cognitive-behavioral therapy for anorexia nervosa; CBT-E, enhanced cognitive-behavioral therapy; Cr, creatinine; DSM-5-TR, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision; DXA, dual-energy X-ray absorptiometry; ECG, electrocardiogram; ECHO, Experienced Carers Helping Others; FBT, family-based therapy/treatment; FPT, focal psychodynamic psychotherapy; GFR, glomerular filtration rate; MANTRA, Maudsley Model of Anorexia Nervosa Treatment for Adults; mmHg, mm mercury; OCD, obsessive-compulsive disorder; PTSD, posttraumatic stress disorder; QTc, corrected QT interval; sBP, systolic blood pressure; SSCM, Specialist Supportive Clinical Management; SPT, supportive psychotherapy

Source

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