AMERICAN PSYCHIATRIC ASSOCIATION

Treatment of Patients With Eating Disorders

Key Points

Assessment

Treatment

GuidelineCentral.com®

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	
Grade	**Description**
1	*Recommendation*: indicates confidence that the benefits of the intervention clearly outweigh harms.
2	*Suggestion*: 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.
Grade	**Strength of Evidence**
A	*High*: high confidence that the evidence reflects the true effect. Further research is very unlikely to change our confidence in the estimate of effect.
B	*Moderate*: 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.
C	*Low*: 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.

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)	
Y / N	Do you make yourself **S**ick because you feel uncomfortably full?
Y / N	Do you worry you have lost **C**ontrol over how much you eat?
Y / N	Have you recently lost >14 lbs (**O**ne stone) in a 3-month period?
Y / N	Do you believe yourself to be **F**at when others say you are too thin?
Y / N	Would you say that **F**ood dominates your life?
Y / N	*To assess for binge-eating disorder, add:* 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)?
Screen for Disordered Eating (Maguen et al. 2018)	
Y / N	Do you often feel the desire to eat when you are emotionally upset or stressed?
Y / N	Do you often feel that you can't control what or how much you eat?
Y / N	Do you sometimes make yourself throw up (vomit) to control your weight?
Y / N	Are you often preoccupied with a desire to be thinner?
Y / N	Do you believe yourself to be fat when others say you are too thin?
Eating Disorder Screen for Primary Care (Cotton et al. 2003)	
Y / N	Are you satisfied with your eating patterns? Answering "no" to this question is classified as an abnormal response.
Y / N	Do you ever eat in secret? Answering "yes" to this and all other questions is classified as an abnormal response.
Y / N	Does your weight affect the way you feel about yourself?
Y / N	Have any members of your family suffered with an eating disorder?
Y / N	Do you make yourself sick because you feel uncomfortably full?

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.**

Initial Review of Systems

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

Organ System	Symptom/*Sign*[1]	
	Related to nutritional restriction	Related to purging
General	*Low weight, cachexia*	
General	Fatigue	
General	*Weakness*	*Weakness*
General	*Dehydration*	
General	Cold intolerance, *low body temperature*	
General	Hot flashes, sweating	
Nervous system	Anxiety, depression, or irritability	Anxiety, depression, or irritability
Nervous system	Apathy	Apathy
Nervous system	Poor concentration	Poor concentration
Nervous system	Headache	Headache
Nervous system	*Seizures* (in severe cases)	*Seizures* (in severe cases)
Nervous system		*Paresthesia* (due to electrolyte abnormalities)
Nervous system	*Peripheral polyneuropathy* (in severe cases)	
Oropharyngeal	Dysphagia	
Oropharyngeal		*Dental enamel erosion and decay*
Oropharyngeal		*Enlarged salivary glands*
Oropharyngeal		Pharyngeal pain
Oropharyngeal		*Palatal scratches, erythema, or petechiae*

Table 3. Signs and Symptoms of Eating Disorders *(cont'd)*

Organ System	Symptom/*Sign*[1]	
	Related to nutritional restriction	**Related to purging**
Gastrointestinal	Abdominal discomfort	Abdominal discomfort
Gastrointestinal	Constipation	Constipation
Gastrointestinal		Diarrhea (due to laxative use)
Gastrointestinal	Nausea	
Gastrointestinal	Early satiety	
Gastrointestinal	*Abdominal distention,* bloating	*Abdominal distention*, bloating
Gastrointestinal		Heartburn, *gastroesophageal erosions or inflammation*
Gastrointestinal		*Vomiting, possibly blood-streaked*
Gastrointestinal		*Rectal prolapse*
Cardiovascular	Dizziness, faintness, *orthostatic hypotension*	Dizziness, faintness, *orthostatic hypotension*
Cardiovascular	Palpitations, *arrhythmias*	Palpitations, *arrhythmias*
Cardiovascular	*Bradycardia*	
Cardiovascular	*Weak irregular pulse*	
Cardiovascular	*Cold extremities, acrocyanosis*	
Cardiovascular	Chest pain	
Cardiovascular	*Dyspnea*	
Reproductive/ Endocrine	*Slowing of growth (in children or adolescents)*	*Slowing of growth (in children or adolescents)*
Reproductive/ Endocrine	*Arrested development of secondary sex characteristics*	*Arrested development of secondary sex characteristics*
Reproductive/ Endocrine	Low libido	Low libido
Reproductive/ Endocrine	*Fertility problems*	
Reproductive/ Endocrine	*Oligomenorrhea*	*Oligomenorrhea*
Reproductive/ Endocrine	*Primary or secondary amenorrhea*	

Table 3. Signs and Symptoms of Eating Disorders *(cont'd)*

Organ System	Symptom/*Sign*[1]	
	Related to nutritional restriction	**Related to purging**
Musculoskeletal	*Proximal muscle weakness, wasting, or atrophy*	
Musculoskeletal		Muscle cramping
Musculoskeletal	Bone pain[2]	Bone pain[2]
Musculoskeletal	*Stress fractures*[2]	*Stress fractures*[2]
Musculoskeletal	*Slowed growth (relative to expected)*[2]	*Slowed growth (relative to expected)*[2]
Dermatological	*Dry, yellow skin*	
Dermatological	*Change in hair including hair loss and dry and brittle hair*	
Dermatological	*Lanugo*	
Dermatological		*Scarring on dorsum of hand (Russell's sign)*
Dermatological	*Poor skin turgor*	*Poor skin turgor*
Dermatological	*Pitting edema (with refeeding)*	*Pitting edema*

[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 4. Laboratory Abnormalities Related to Nutritional Restriction or Purging Behaviors

Recommendation	Organ system	Test
Recommended	Cardiovascular	ECG
Recommended	Metabolic	Serum electrolytes
		Lipid panel
		Serum glucose
Recommended	Gastrointestinal	Liver function and associated tests
Recommended	Genitourinary	Renal function tests
Based on history or exam	Genitourinary	Urinalysis
Based on history or exam	Reproductive	Serum gonadotropins and sex hormones
Based on history or exam	Skeletal	Bone densitometry (DXA scan)
Incidental	Oropharyngeal	Dental radiography

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

	Related to nutritional restriction	Related to purging
	Bradycardia or arrhythmias, QTc prolongation	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
	Hypokalemia, hyponatremia, hypomagnesemia, hypophosphatemia (especially on refeeding)	Hypokalemia, hyponatremia, hypochloremia, hypomagnesemia, hypophosphatemia, metabolic acidosis
	Hypercholesterolemia	
	Low blood sugar	
	Elevated liver function tests	
	Increased BUN, decreased GFR, decreased Cr because of low lean body mass (normal Cr may indicate azotemia), renal failure (rare)	Increased BUN and Cr, renal failure (rare)
	Urinary specific gravity abnormalities	Urinary specific gravity abnormalities, high pH
	Decreased serum estrogen or serum testosterone; prepubertal patterns of luteinizing hormone, follicle stimulating hormone secretion	May be hypoestrogenemic if menstrual irregularities are present
	Reduced BMD, osteopenia, or osteoporosis in individuals with previous low weight and menstrual irregularity or amenorrhea	Reduced BMD, osteopenia or osteoporosis in individuals with previous low weight and menstrual irregularity or amenorrhea
		Erosion of dental enamel

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 5. Considerations in Determining an Appropriate Level of Care

• 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)
• 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)
• Co-occurring conditions (e.g., diabetes, substance use disorders) that would significantly affect treatment needs and require a higher level of care.
• Lack of response or deterioration in patient's condition in individuals receiving outpatient treatment
• 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
• Level of motivation to recover, including insight, cooperation with treatment, and willingness to engage in behavior change
• Psychosocial context, including level of environmental and psychosocial stress and ability to access support systems
• 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)

Table 6. Factors Supporting Medical Hospitalization or Hospitalization on a Specialized Eating Disorder Unit

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

[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

	Adolescents (12–19 years)
	<50 bpm
	Sustained increase of >40 bpm
	<90/45 mmHg
	>20 mmHg drop in sBP
	<60 mg/dL
	Hypokalemia[1]
	Hyponatremia[1]
	Hypophosphatemia[1]
	Hypomagnesemia[1]
	<36° C (<96.8° F)
	<75% of median BMI for age and sex
	>10% weight loss in 6 months or >20% weight loss in 1 year
	Occur frequently and have either caused serious physiological consequences or not responded to treatment at a lower level of care
	Prolonged QTc >450 or other significant ECG abnormalities
	Acute medical complications of malnutrition (e.g., seizures, syncope, cardiac failure, pancreatitis), arrested growth and development

Table 7. Characteristics of Levels of Care

Level of care	Specialized pediatric/medical inpatient eating disorders program
Unit security	Unlocked
Patient legal status	Voluntary or involuntary
Physician on-site 24/7	On-site 24/7
Nursing on-site 24/7	On-site 24/7
Medical monitoring	Frequent
Hours of operation	24/7
Able to maintain work/school	School, in some instances
Available interventions	
Option for IV hydration	Yes
Option for nasogastric tube feedings	Yes
Option for treatment over objection	Yes
Medical management	Yes
Psychiatric management	Yes
Psychological management	Yes
Group-based therapies	Yes
Individual psychotherapies	Yes
Family psychotherapies	Yes
Meal supervision and support	All meals/day
Milieu therapy	Yes
Nutritional management	Yes
Multi-disciplinary team-based management	Yes

	General pediatric/ medical inpatient program	Specialized psychiatric inpatient eating disorders program	General psychiatric inpatient program
	Unlocked	Typically locked	Typically locked
	Voluntary	Voluntary or involuntary	Voluntary or involuntary
	On-site 24/7	On-call or on-site 24/7	On-call or on-site 24/7
	On-site 24/7	On-site 24/7	On-site 24/7
	Frequent	Frequent	Frequent
	24/7	24/7	24/7
	School, in some instances	School, in some instances	School, in some instances
	Yes	On some units	On some units
	Yes	On some units	On some units
	Yes	Yes	Yes
	Yes	Consultation	Consultation
	Consultation	Yes	Not eating disorder-specific
	In some instances	Yes	On some units, not eating disorder specific
	No	Yes	Not eating disorder-specific
	Generally not available	Yes	Not eating disorder-specific
	Generally not available	On some units	Not eating disorder-specific
	In some instances	All meals/day	Not eating disorder-specific
	No	Yes	Not eating disorder-specific
	Consultation	Yes	Consultation
	In some instances, not eating disorder specific	Yes	Not eating disorder-specific

Table 7. Characteristics of Levels of Care *(cont'd)*	
Level of care	**Residential program**
Unit security	Unlocked
Patient legal status	Voluntary
Physician on-site 24/7	On-call 24/7
Nursing on-site 24/7	Typically on-site 24/7
Medical monitoring	Limited
Hours of operation	24/7
Able to maintain work/school	School, in some instances
Available interventions	
Option for IV hydration	No
Option for nasogastric tube feedings	Typically not
Option for treatment over objection	No
Medical management	Limited consultation
Psychiatric management	Yes
Psychological management	Yes
Group-based therapies	Yes
Individual psychotherapies	Yes
Family psychotherapies	Yes
Meal supervision and support	All meals/day
Milieu therapy	Yes
Nutritional management	Yes
Multi-disciplinary team-based management	Yes

	Partial hospital	Intensive outpatient	Outpatient
	Unlocked	Unlocked	Unlocked
	Voluntary	Voluntary	Voluntary
	Typically not on-site full-time	Not on-site full-time	No
	Typically not on-site full-time	Typically not on-site	No
	Limited	Limited	As indicated
	Variable hours per day (5–12 hours) and days per week (5–7)	3–4 hours per day, 3–7 days per week	1–2 psychotherapy sessions per week with additional visits with other clinicians as indicated
	School, in some instances	Often	Yes
	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
	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

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

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.**

	CBT-AN	CBT-E	FPT	SSCM	MANTRA	ECHO	AFT	FBT
	×	×		×	×			×
	×	×	×		×		×	×
	×	×	×		×	×	×	
	×	×	×	×	×	×	×	(indirectly)
	×	×	×	×	×	×	×	×
	×	×						
	×	×		If raised by patient		×		×
	×	×			×			×
						×		×

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

American Psychiatric Association: Practice Guideline for the Treatment of Patients with Eating Disorders, Fourth Edition. Washington, DC, American Psychiatric Publishing 2023.

The review of the content included in this Pocket Guide was funded in part by the Gordon and Betty Moore Foundation through a grant program administered by the Council of Medical Specialty Societies.

Disclaimer

International Guidelines Center

1258 Upsala Rd
Sanford, FL 32771
TEL: 407.878.7606 • FAX: 407.878.7611
Order additional copies at GuidelineCentral.com

APAEAT02233a