

TREATING EATING DISORDERS

A Quick Reference Guide



Based on *Practice Guideline for the Treatment of Patients With Eating Disorders*,
Second Edition, originally published in January 2000.

For Continuing Medical Education credit
for APA Practice Guidelines,
visit www.psych.org/cme.

To order individual Practice Guidelines or the
2002 Compendium of APA Practice Guidelines,
visit www.appi.org or call **800-368-5777**.

Introduction

“Treating Patients With Eating Disorders: A Quick Reference Guide” is a summary and synopsis of the American Psychiatric Association’s *Practice Guidelines for the Treatment of Patients with Eating Disorders*, Second Edition, which was originally published in *The American Journal of Psychiatry* in January 2000 and is available through American Psychiatric Publishing, Inc. The Quick Reference Guide is not designed to stand on its own and should be used in conjunction with the full text of the Practice Guideline. Graphical algorithms illustrating the treatment of patients with eating disorders are included.

Statement of Intent

The Practice Guidelines and the Quick Reference Guides are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

The development of the APA Practice Guidelines and Quick Reference Guides has not been financially supported by any commercial organization.

OUTLINE

A. Initial Assessment and Diagnosis

1. Diagnostic Criteria.....5
2. General Medical Status5
3. Potential for Dangerousness6
4. Eating Disorder Symptoms and Behaviors.....6
5. Other Psychiatric Symptoms and Behaviors7
6. Psychiatric History7
7. Developmental and Psychosocial History7
8. Family Issues7

B. Psychiatric Management

- Establish and maintain a therapeutic alliance8
- Provide and/or coordinate care and collaborate with other clinicians8
- Monitor eating disorder symptoms and behaviors8
- Ensure that the patient's general medical status is monitored8
- Monitor the patient's psychiatric status, safety, and comorbid conditions8

D. Treatment

1. Anorexia Nervosa
 - a. Treatment Setting 11
 - b. Nutritional Rehabilitation 13
 - c. Psychosocial Treatments 14
 - d. Medications 15
2. Bulimia Nervosa
 - a. Treatment Setting 16
 - b. Nutritional Rehabilitation 16
 - c. Psychosocial Treatments 17
 - d. Medications 18

C. Treatment Goals and Ongoing Assessment

1. Anorexia Nervosa9
2. Bulimia Nervosa 10



A. Initial Assessment and Diagnosis

The psychiatrist will consider the following areas of assessment:

1. Diagnostic Criteria

Review DSM-IV-TR criteria for anorexia nervosa (DSM-IV-TR, p. 589) and bulimia nervosa (DSM-IV-TR, p. 594).

2. General Medical Status

Conduct a physical examination with particular attention to the following:

- Vital signs
- Weight
- Physical and sexual growth and development
- Cardiovascular system and evidence of dehydration
- Lanugo
- Salivary gland enlargement
- Russell's sign (scarring on dorsum of hand)

Review dental examination results.

Conduct laboratory analyses, as indicated.

For laboratory assessments and their patient indications, refer to Appendix A in this guide (p. 20).

3. Potential for Dangerousness

- **Determine danger to self.**
Assess current suicidal ideation, history of suicidal ideation, suicide attempts, and self-mutilation.
- **Determine access to means for suicide.**

4. Eating Disorder Symptoms and Behaviors

- **Obtain a detailed report of a single day.**
- **Observe the patient during a meal.**
- **Assess related psychological symptoms—for example, obsessional thoughts related to weight, shape, and eating.**
- **Determine the patient's insight into the presence of the disorder and the patient's motivation for change.**
- **Explore the patient's understanding of how the illness developed and the effects of interpersonal problems on onset.**
- **Identify those stressors that exacerbate the symptoms of the eating disorder.**
- **Consider the use of formal measures—for example, scales for assessments of symptoms such as binge frequency.**

5. Other Psychiatric Symptoms and Behaviors

→ **Assess the following:**

- Mood symptoms and disorders
- Anxiety symptoms and disorders
- Obsessions/compulsions
- Substance abuse
- Shoplifting; other impulsive behaviors
- Personality disturbances

6. Psychiatric History

→ **Assess previous episodes and previous treatment response.**

7. Developmental and Psychosocial History

→ **Assess the following:**

- Psychological, sexual, or physical abuse
- Sexual history
- Psychodynamic and interpersonal conflicts relevant to understanding and treating the patient's eating disorder

8. Family Issues

→ **Assess the following:**

- Family history of eating disorders, other psychiatric disorders, obesity
- Family reactions to disorder; attitudes toward eating, exercise, and appearance
- Burden of illness on family
- Family dynamics: guilt, blame

B. Psychiatric Management

Throughout the formulation of a treatment plan and the subsequent course of treatment, the following principles of psychiatric management should be kept in mind:

→ **Establish and maintain a therapeutic alliance.**

- Adapt and modify therapeutic strategies as the disorder and the therapeutic alliance change over time.
- Build the alliance by acknowledging the patient's difficulties in gaining weight.
- Be aware of countertransference reactions.
- Set clear boundaries.

→ **Provide and/or coordinate care and collaborate with other clinicians.**

- Collaborate with providers of nutritional counseling, family work, and various psychotherapeutic programs (e.g., individual, group, cognitive/behavioral).
- Consult with other physician specialists and dentists.
- Educate and supervise inexperienced staff.

→ **Monitor eating disorder symptoms and behaviors.**

→ **Ensure that the patient's general medical status is monitored.**

- Weight and vital signs
- Food and fluid intake and output
- Periodic physical examinations, with special attention to signs of edema and fluid overload
- Urine specific gravity
- Minerals and electrolytes

→ **Monitor the patient's psychiatric status, safety, and comorbid conditions.**

C. Treatment Goals and Ongoing Assessment

Following diagnosis, set treatment goals, assess ongoing progress, and adjust goals accordingly. Other treatment goals may be identified, depending on the patient's needs and condition.

1. Anorexia Nervosa

→ *Restore healthy weight.*

→ **Treat physical complications.**

→ **Enhance the patient's motivation to cooperate and participate in treatment.**

→ **Provide education about healthy nutrition and eating patterns.**

→ **Correct core maladaptive thoughts and attitudes.**

→ **Treat associated psychiatric conditions, including defects in mood regulation, self-esteem, and behavior.**

→ **Enlist family support and provide family counseling and therapy where appropriate.**

→ **Prevent relapse.**

2. Bulimia Nervosa

→ *Reduce binge eating and purging behaviors.*

→ **Improve attitudes related to eating disorders.**

→ **Minimize food restrictions.**

→ **Encourage healthy but not excessive exercise.**

→ **Treat comorbid conditions.**

→ **Address underlying themes:**

- Developmental issues
- Identity formation
- Body image concerns
- Self-esteem in areas outside weight and shape
- Difficulties with sexual issues and aggression
- Affect regulation
- Gender role expectations
- Family dysfunction
- Coping styles

D. Treatment

1. Anorexia Nervosa

a. Treatment Setting

Weight and cardiac status are the most important physical parameters in determining choice of setting. The strategy is to hospitalize *before* a patient becomes medically unstable.

Medical indications for inpatient hospitalization

Adults

- Weight < 75% of standard
- Heart rate < 40 bpm
- Blood pressure < 90/60 mm Hg
- Glucose < 60 mg/dL
- Potassium < 3 mEq/L
- Electrolyte imbalance
- Temperature < 97.0°F
- Dehydration
- Hepatic, renal, or cardiovascular organ compromise requiring acute treatment

Children and Adolescents

- Weight < 75% of standard or acute weight decline with food refusal
- Heart rate 40–49 bpm
- Orthostatic hypotension (with an increase in pulse of > 20 bpm or a drop in blood pressure of > 10–20 mm Hg/minute from supine to standing)
- Blood pressure < 80/50 mm Hg
- Hypokalemia or hypophosphatemia

Other factors influencing decision about inpatient hospitalization

- Suicidal intent and plan
- Poor motivation to recover
- Preoccupation with ego-syntonic thoughts
- Uncooperative with treatment or cooperative only in highly structured settings
- Any existing psychiatric disorder that would require hospitalization
- Need for supervision during and after all meals and in bathrooms
- Presence of additional stressors interfering with ability to eat (e.g., intercurrent viral illnesses)
- Knowledge of weight at which instability is likely to occur

1. Anorexia Nervosa
a. Treatment Setting (continued)

→ **Psychiatric versus general hospitalization**

Consider the following:

- General medical status of the patient
- Skills and abilities of local care providers
- Availability of suitable intensive outpatient, partial and day hospitalization, and aftercare programs

→ **Patient factors influencing decision about placement in a residential treatment center**

- Medical stability to the extent that intravenous fluids, nasogastric tube feedings, or multiple daily laboratory tests are not needed
- Weight < 85% of standard
- Poor to fair motivation to recover
- Preoccupation with ego-syntonic maladaptive thoughts about 4 to 6 hours a day; cooperative with highly structured treatment
- Need for supervision at all meals to prevent restrictive eating
- Pronounced role impairment and inability to eat and gain weight by self
- Need for structure to prevent compulsive exercising
- Severe family conflict or problems; absence of family, adequate support system, or both

→ **Patient factors influencing decision about partial hospitalization (full-day outpatient care)**

- Partial motivation to recover
- Preoccupation with ego-syntonic maladaptive thoughts at least 3 hours a day
- Need for structure to gain weight
- Need for structure to prevent compulsive exercising
- Presence of comorbid psychiatric conditions requiring intensive treatment

1. Anorexia Nervosa

b. Nutritional Rehabilitation

Phase 1: Refeeding and weight gain

- Establish the target weight and rates of weight gain: a healthy goal weight is the weight at which normal menstruation and ovulation are restored or, in premenarchal girls, the weight at which normal physical and sexual development resumes.
- Usually start intake at 30 to 40 kcal/kg per day (approximately 1,000 to 1,600 kcal/day); intake may be increased to as high as 70 to 100 kcal/kg per day.
- Nasogastric feeding is reserved for the rare patients who are extremely unable to recognize their illness, accept the need for treatment, or tolerate guilt accompanying active eating even when performed to sustain life.
- Add vitamin and mineral supplements; for example, phosphorus supplementation may be particularly useful to prevent serum hypophosphatemia.
- Help the patient limit physical activity and caloric expenditure according to food intake and fitness requirements.
- Monitor vital signs; food and fluid intake/output; electrolytes; signs of fluid overload (e.g., presence of edema, rapid weight gain, congestive heart failure); and gastrointestinal symptoms, particularly constipation and bloating. Provide cardiac monitoring, especially at night, for children and adolescents who are severely malnourished.

Phase 2: Weight maintenance

- Once the desired weight is achieved, calculate ongoing caloric intake based on weight and activity. For children and adolescents, intake levels at 40 to 60 kcal/day are often needed for growth and maturation.
- Help the patient deal with concerns about weight gain and body image changes.
- Educate about the risks of eating disorders.
- Provide ongoing support to the patient and the family.

1. Anorexia Nervosa

c. Psychosocial Treatments

Establishing and maintaining a psychotherapeutically informed relationship with the patient is important and beneficial. Psychosocial interventions need to be informed by an understanding of psychodynamic conflicts, cognitive development, psychological defenses, and the complexity of family relationships, as well as the presence of other psychiatric disorders. Formal psychotherapy may be helpful after weight gain has started.

→ **Individual psychotherapy**

Usually required for at least 1 year. May take 5 to 6 years because of the enduring nature of the illness and the need for support during recovery.

→ **Family and couples therapy**

Useful when problems in familial relationships are contributing to the maintenance of the disorder.

→ **Group psychotherapy**

Care must be taken to help patients avoid competition to be thinnest or sickest and to deal with patient demoralization from observation of the difficult, chronic course of the illness.

1. Anorexia Nervosa

d. Medications

Psychotropic medications should not be relied on as the sole or primary treatment of anorexia nervosa. Decisions concerning use of medications are often deferred until weight has been restored because many symptoms (including depression) diminish considerably when weight is gained.

After weight restoration

- Antidepressants for persistent depression or anxiety
- Selective serotonin reuptake inhibitors (SSRIs) for obsessive-compulsive symptoms

Additional considerations

- Malnourished, depressed patients are more prone to side effects.
- Bupropion should be avoided in patients with eating disorders.
- Tricyclic antidepressants (TCAs) should be avoided in underweight patients and those at risk for suicide.
- Cardiovascular consultation may be helpful if there is concern about the potential cardiovascular effects of a medication.

2. Bulimia Nervosa

a. Treatment Setting

Most patients with uncomplicated bulimia nervosa do not require hospitalization.

Factors supporting inpatient hospitalization

- Severe, disabling symptoms that have not responded to outpatient treatment
- Serious concurrent general medical problems (e.g., metabolic abnormalities, hematemesis, vital sign changes, or the appearance of uncontrolled vomiting)
- Suicidality
- Severe concurrent alcohol or drug abuse

2. Bulimia Nervosa

b. Nutritional Rehabilitation

Weight restoration is usually not a primary focus of treatment for bulimia nervosa because patients are not severely underweight.

Nutritional counseling is helpful for the following:

- Establishing a pattern of regular, nonbinge meals
- Increasing the variety of foods eaten
- Correcting nutritional deficiencies
- Minimizing food restriction
- Encouraging healthy but not excessive exercise patterns

2. Bulimia Nervosa

c. Psychosocial Treatments

Psychosocial interventions should be informed by a comprehensive evaluation of the patient, including cognitive and psychological development, psychodynamic issues, cognitive style, comorbid psychopathology, patient preferences, and family situation. Controlled studies have been short-term, but long-term psychotherapy may be needed for patients with concurrent anorexia nervosa or severe personality disorders.

→ **Cognitive behavior therapy**

- Effective as a short-term intervention when specifically directed at eating disorder symptoms and underlying maladaptive cognitions
- Useful in reducing binge-eating symptoms and improving attitudes about shape, weight, and restrictive dieting

→ **Interpersonal psychotherapy, psychodynamically oriented and psychoanalytic approaches, and behavior techniques (e.g., planned meals, self-monitoring) may also be helpful.**

→ **Group psychotherapy**

- Can help the patient with shame about the disorder
- Provides peer-based feedback and support
- Is more useful if dietary counseling and management are included in the program

→ **Family and marital therapy**

Should be considered especially for adolescents who live with parents, for older patients with ongoing conflicted interaction with parents, or for patients with marital discord

2. Bulimia Nervosa

d. Medications

Indications

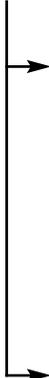
- To reduce frequency of disturbed eating behaviors (binge eating and vomiting)
- To prevent relapse—most clinicians recommend continuation for 6 months to 1 year
- To reduce associated symptoms (e.g., depression, anxiety, obsessions, symptoms related to impulse control)

Considerations

- Various antidepressants may have to be tried sequentially to achieve optimum effect.
- If no response, the clinician should assess whether the patient has taken medication shortly before vomiting; serum levels may be helpful.
- A combination of psychotherapy and medication may be superior to either alone.

Classes

- SSRIs are considered safest and are helpful for depression, anxiety, obsessions, and certain impulse disorder symptoms and for patients with a suboptimal response to appropriate psychosocial therapy. Doses may need to be higher than those used to treat depression (e.g., 60 to 80 mg of fluoxetine).
- Antidepressant medications from a variety of other classes can reduce the symptoms of binge eating and purging and may help prevent relapse.



Caveats

- TCAs should be used with caution for patients at high risk of suicide.
- Monoamine oxidase inhibitors (MAOIs) should be avoided for patients with chaotic binge eating and purging.
- Bupropion should be avoided in patients with bulimia because of increased seizure risk.

Side effects and toxicity

- SSRIs: insomnia, nausea, asthenia, sexual side effects.
- TCAs: sedation, constipation, dry mouth, weight gain.
- For patients who need mood stabilizers, lithium carbonate may be particularly problematic, because levels can shift markedly with rapid volume changes. Both lithium and valproic acid are associated with undesirable weight gain.

APPENDIX A. Laboratory Assessments for Patients With Eating Disorders

Assessment	Condition
<p>Basic analyses</p> <ul style="list-style-type: none"> Blood chemistry studies <ul style="list-style-type: none"> Serum electrolyte level Blood urea nitrogen (BUN) level Creatinine level Thyroid function test Complete blood count (CBC) Urinalysis 	<ul style="list-style-type: none"> • Consider for all patients with eating disorders
<p>Additional analyses</p> <ul style="list-style-type: none"> Blood chemistry studies <ul style="list-style-type: none"> Calcium level Magnesium level Phosphorus level Liver function tests Electrocardiogram 	<ul style="list-style-type: none"> • Consider for malnourished and severely symptomatic patients
<p>Osteopenia and osteoporosis assessments</p> <ul style="list-style-type: none"> Dual-energy X-ray absorptiometry (DEXA) Estradiol level Testosterone level in males 	<ul style="list-style-type: none"> • Consider for patients underweight more than 6 months
<p>Nonroutine assessments</p> <ul style="list-style-type: none"> Serum amylase level Luteinizing hormone (LH) and follicle-stimulating hormone (FSH) levels Brain magnetic resonance imaging (MRI) and computed tomography (CT) Stool 	<ul style="list-style-type: none"> • Consider only for specific indications • Possible indicator of persistent or recurrent vomiting • For persistent amenorrhea at normal weight • For ventricular enlargement correlated with degree of malnutrition • Occult blood loss; suspected surreptitious laxative abuse