

TREATING EATING DISORDERS

A Quick Reference Guide



Based on *Practice Guideline for the Treatment of Patients With Eating Disorders*, Third Edition, originally published in July 2006. A guideline watch, summarizing significant developments in the scientific literature since publication of this guideline, may be available in the Psychiatric Practice section of the APA web site at www.psych.org.

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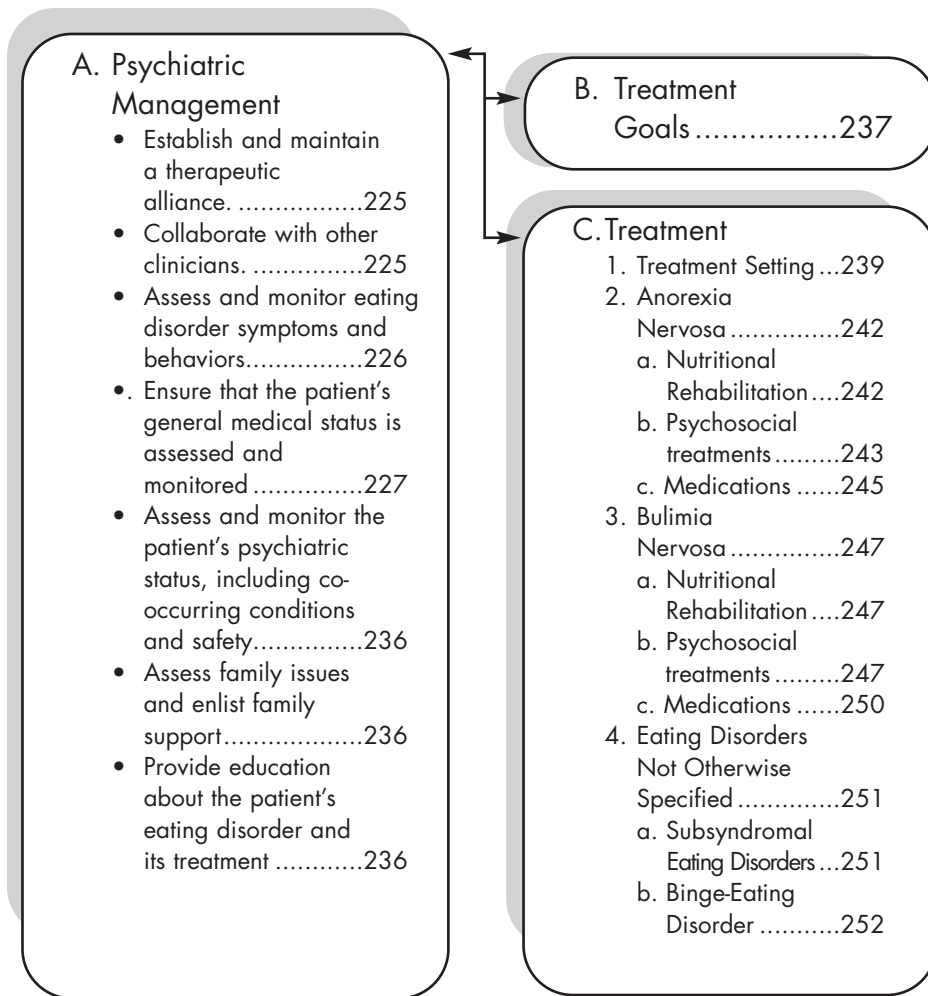
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Statement of Intent

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 patient 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 for every individual, nor should they be interpreted 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. For more detail, see APA's "Practice Guideline Development Process," available as an appendix to the compendium of APA practice guidelines, published by APPI, and online at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm.

OUTLINE



A. Psychiatric Management

Throughout the process of assessment, diagnosis, and formulation and implementation of a treatment plan, the following principles of psychiatric management should be kept in mind:

Establish and maintain a therapeutic alliance.

- Enhance development of the alliance through empathic comments and behaviors, positive regard, reassurance, and support.
- Recognize and acknowledge anxieties that patients with anorexia nervosa have about gaining weight.
- Be aware that many patients may withhold information about their behaviors because of shame.
- Set clear boundaries.
- Be aware of countertransference reactions.
- Adapt and modify therapeutic strategies as the disorder and the therapeutic alliance change over time.

Collaborate with other clinicians.

- Provide and/or coordinate care.
- Collaborate with other individuals who are involved in the patient's treatment, including other physicians, registered dietitians, mental health professionals, and school personnel.
- Consult with other physician specialists and dentists.
- Educate and supervise inexperienced staff.

A. Psychiatric Management (*continued*)

Assess and monitor eating disorder symptoms and behaviors.

- Use DSM-IV-TR criteria to guide diagnosis and identification of target symptoms and behaviors.
- Obtain history of previous episodes of eating disorder, including previous treatment response.
- Assess specific eating-related behaviors by
 - obtaining a detailed report of food intake during a single day,
 - observing the patient during a meal, and
 - recording food and/or fluid intake and output as part of nutritional management.
- Consider the use of formal measures (e.g., semistructured interviews, rating scales, self-report questionnaires).
- Assess related psychological symptoms (e.g., obsessional thoughts related to weight, shape, and eating).
- Explore the patient's understanding of how the illness developed and the effects of interpersonal issues on onset, including aspects of sexual history and psychological, physical, or sexual abuse.
- Identify stressors that exacerbate the symptoms of the eating disorder.
- Identify relevant psychodynamic and interpersonal conflicts.
- Determine the patient's insight into the presence of the disorder and the patient's motivation for change.

Ensure that the patient's general medical status is assessed and monitored.

- Ensure that a physical examination is conducted by a physician knowledgeable about eating disorders:
 - Vital signs
 - Weight and height, including calculation of BMI
 - Physical and sexual growth and development
 - Cardiovascular system, including evidence of dehydration, cardiac arrhythmias, or congestive heart failure
 - Lanugo
 - Salivary gland enlargement
 - Russell's sign (scarring on dorsum of hand)
 - Muscular irritability or weakness
 - Evidence of self-injurious behaviors
- Review dental examination results.
- Conduct laboratory analyses, as indicated. For laboratory assessments and their patient indications, see Table 1, p. 228.
- For commonly found signs, symptoms, and associated laboratory abnormalities, see Table 2, p. 230.

TABLE 1. Laboratory Assessments for Patients With Eating Disorders

Assessment	Patient Indication
Basic analyses	All patients with eating disorders
Blood chemistry studies	
Serum electrolytes	
Blood urea nitrogen	
Serum creatinine (interpretations must incorporate assessments of weight)	
Thyroid-stimulating hormone test; if indicated, free T ₄ , T ₃	
Complete blood count including differential	
Erythrocyte sedimentation rate	
Aspartate aminotransferase, alanine aminotransferase, alkaline phosphatase	
Urinalysis	
Additional analyses	Malnourished and severely symptomatic patients (Serum magnesium should be obtained prior to administering certain medications if QTc is prolonged.) ^b
Complement component 3 ^a	
Blood chemistry studies	
Serum calcium	
Serum magnesium	
Serum phosphorus	
Serum ferritin	
Electrocardiogram	
24-hour urine for creatinine clearance ^c	
Osteopenia and osteoporosis assessments	Patients amenorrheic for >6 months
Dual-energy X-ray absorptiometry	
Serum estradiol in female patients	
Serum testosterone in male patients	

TABLE 1. Laboratory Assessments for Patients With Eating Disorders (continued)

Assessment	Patient Indication
Nonroutine assessments	
Toxicology screen	Patients with suspected substance use, particularly those with anorexia nervosa, binge/purge subtype, or for patients with bulimia nervosa
Serum amylase (fractionated for salivary gland isoenzyme if available to rule out pancreatic involvement)	Patients with suspected surreptitious vomiting
Serum luteinizing hormone, follicle-stimulating hormone, β -human chorionic gonadotropin, prolactin	Patients with persistent amenorrhea but who are normal weight
Brain magnetic resonance imaging, computed tomography	Patients with significant cognitive deficits, other neurological soft signs, unremitting course, or other atypical features
Stool for guaiac	Patients with suspected gastrointestinal bleeding
Stool or urine for bisacodyl, emodin, aloe-emodin, rhein	Patients with suspected laxative abuse

^aSome experts recommend the routine use of complement component 3 as a sensitive marker that may indicate nutritional deficiencies even when other laboratory test results are apparently in the normal range.

^bDuring hospital refeeding, it is recommended that serum potassium, magnesium, and phosphorus levels be determined daily for 5 days and thereafter at least three times/week for 3 weeks.

^cCreatinine clearance should be calculated with equations that involve body surface using assessments of height and weight.

TABLE 2. Physical Complications of Eating Disorders

Organ System	Signs and Symptoms	Associated Laboratory Abnormalities
Whole body	Low body weight, dehydration, hypothermia, cachexia, weakness and lassitude increase with degree of malnutrition	<i>Weight:</i> Low weight and BMI <i>Anthropometrics:</i> Low body fat percentage by anthropometrics or underwater weighing ^a
Cardiovascular and peripheral vascular	Weakness; faintness; dizziness; orthostatic hypotension; shortness of breath; chest pain; palpitations; arrhythmias; bradycardia; weak irregular pulse; cold extremities; acrocyanosis	<i>ECG:</i> Bradycardia in AN; ST-T wave abnormalities in AN and with hypokalemia; increased PR interval and first-degree heart block in AN; QTc prolongation ^b in AN and with hypokalemia; QT dispersion correlated with weight loss. In severe cases of BN, hypokalemia-widened QRS complex, increased P-wave amplitude, increased PR interval, increased supraventricular and ventricular ectopic rhythms; torsade de pointes correlated with hypokalemia; autonomic dysfunction on spectral analysis <i>Echocardiogram:</i> Mitral valve prolapse and pericardial effusion in AN; cardiomyopathy in ipecac abusers <i>Chest X-ray:</i> Small heart
Central nervous system	Apathy; poor concentration; in AN and severe cases of BN cognitive impairment; anxious, depressed, irritable mood and, less often, seizures, peripheral neuropathy	<i>CT scan:</i> Cortical atrophy, ventricular enlargement <i>PET, fMRI:</i> Abnormal cerebral blood flow and metabolism <i>MRI:</i> Decreased gray and white matter <i>EEG:</i> Nonspecific abnormalities; seizures (rare)

TABLE 2. Physical Complications of Eating Disorders (continued)

Organ System	Signs and Symptoms	Associated Laboratory Abnormalities
Endocrine, metabolic	<p>Fatigue, diuresis, cold intolerance and low body temperature in AN; weight fluctuation, poor skin turgor and pitting edema in BN; rarely, proximal weakness, irritability, muscle cramping, Chvostek's and Trousseau's signs</p>	<p><i>Complete metabolic panel:</i> Electrolyte abnormalities, including hypokalemia (with hypokalemic hypochloremic alkalosis in vomiters); hypomagnesemia (in vomiters, laxative abusers, and AN); hypophosphatemia (in vomiters and laxative abusers and especially on refeeding in AN); hypercholesterolemia in AN; hypoglycemia (rare)</p> <p><i>Urinalysis:</i> Dehydration (increased urine specific gravity, osmolality) with purging or diuretic use</p> <p><i>Thyroid testing:</i> Decreased T₃ with increase in reverse T₃ in AN</p> <p><i>Serum cortisol:</i> Increased serum cortisol in AN</p> <p><i>Vitamin assays:</i> In severe cases, folate, B₁₂, niacin, and thiamine deficiencies in AN</p>
Gastrointestinal	<p>In AN, abdominal pain, bloating, obstipation, constipation, vomiting, abdominal distension with meals, abnormal bowel sounds; acute gastric distension (rare)</p> <p>In vomiters, benign parotid hyperplasia, caries, gingivitis, occasional blood-streaked vomitus; possibly gastritis, esophagitis, gastroesophageal erosions, heartburn, esophageal dysmotility patterns (including gastroesophageal reflux) and, rarely, Mallory-Weiss (esophageal) or gastric tears,</p>	<p><i>Liver function tests:</i> Occasionally abnormal liver function test results</p> <p><i>Serum amylase:</i> Increased serum amylase in purging patients (if fractionation is available, usually salivary gland isoenzymes); increased pancreatic amylase (rare), possibly indicating laxative abuse or other causes for pancreatic inflammation or pancreatitis</p> <p><i>Gastric motility testing:</i> In AN, delayed gastric emptying, increased whole bowel and colonic transit time, anorectal dysfunction</p>

TABLE 2. Physical Complications of Eating Disorders (continued)

Organ System	Signs and Symptoms	Associated Laboratory Abnormalities
Gastrointestinal (continued)	perforation, or necrosis; increased rates of pancreatitis; abdominal pain and discomfort; involuntary vomiting, obstipation, constipation In chronic laxative abusers, possibly bloating, colonic dysmotility or melanosis coli In patients with vitamin deficiencies, angular stomatitis, glossitis, diarrhea	Endoscopy: Occasional inflammation or Barrett's esophagus Radiography: Rarely, superior mesenteric artery syndrome, pancreatitis Stool for guaiac: Occasionally positive because of purging or laxative abuse
Genitourinary	In AN, decreased or increased urinary volume ^c	Renal function tests: In AN, increased blood urea nitrogen, decreased glomerular filtration rate, decreased serum creatinine because of low lean body mass (normal creatinine may indicate azotemia), renal failure (rare) Other renal findings: In AN, greater formation of renal calculi, hypovolemic nephropathy, hypokalemic nephropathy
Hematologic	In AN, fatigue, cold intolerance, bruising/ clotting abnormalities (rare)	Complete blood count: In AN, anemia (may be normocytic, microcytic, or macrocytic); leukopenia with relative lymphocytosis; low erythrocyte sedimentation rate; thrombocytopenia; clotting factor abnormalities (rare) Other hematologic abnormalities: In AN, decreased serum ferritin, B ₁₂ , folate

TABLE 2. Physical Complications of Eating Disorders (continued)

Organ System	Signs and Symptoms	Associated Laboratory Abnormalities
Immune system	Fewer than expected viral infections in AN but may develop viral infections during weight restoration, reduced febrile response to bacterial infection	Multiple unexplained immune system abnormalities; abnormalities in tumor necrosis factor- α and interleukin subtypes
Integument	In AN, change in hair, including lanugo; hair loss and dry and brittle hair; self-injury marks; numerous integumentary abnormalities, including xerosis, carotenoderma (yellowing of skin), and acne In vomiters, scarring on dorsum of hand (Russell's sign); petechia; conjunctival hemorrhages shortly after vomiting	Vitamin assays: In AN, increased serum carotene; in severe cases, vitamin deficiencies (e.g., niacin)
Muscular	With severe malnutrition or ipecac-associated peripheral myopathy, muscle weakness, muscle aches, cramps; in severe cases, muscle wasting	Enzyme tests: With severe malnutrition, creatine kinase and other muscle enzyme abnormalities; creatine kinase isoenzymes for skeletal vs. cardiac source
Oropharyngeal	In vomiters, dental caries with erosion of dental enamel, particularly the lingular surface of incisors; pain and erythema of pharynx; palatal scratches; swollen cheeks and neck (usually painless); enlarged salivary glands	Radiography: Erosion of dental enamel Serum amylase: Increased serum amylase associated with benign parotid hyperplasia
Pulmonary	With severe malnutrition, reduced aerobic capacity and wasting of respiratory muscles	Pulmonary function tests: With severe malnutrition, decreased pulmonary capacity

TABLE 2. Physical Complications of Eating Disorders (continued)

Organ System	Signs and Symptoms	Associated Laboratory Abnormalities
Reproductive	<p>In AN, loss of menses or primary amenorrhea; arrested sexual development or regression of secondary sex characteristics and psychosexual maturation or interest; loss of libido, fertility problems; higher rates of pregnancy complications and neonatal complications. Deficiencies in the mother can result in deficiencies in the fetus.</p> <p>In BN, fertility problems and oligomenorrhea or amenorrhea</p>	<p><i>Serum gonadotropins:</i> Decreased serum estrogen in female patients with AN or BN; decreased serum testosterone in male patients; prepubertal patterns of luteinizing hormone, follicle-stimulating hormone secretion with amenorrhea</p> <p><i>Pelvic ultrasound:</i> Lack of follicular development and/or lack of dominant follicle with amenorrhea</p>

TABLE 2. Physical Complications of Eating Disorders (continued)

Organ System	Signs and Symptoms	Associated Laboratory Abnormalities
Skeletal	Bone pain with exercise; point tenderness; in severe cases, short stature and arrested skeletal growth (more likely in AN than in BN)	<p><i>Radiography and bone scans:</i> Increased rate of pathological stress fractures (more likely in AN than BN)^d; delayed bone age in some patients with AN</p> <p><i>DEXA:</i> Osteopenia or osteoporosis, especially in hip and lumbar spine (more likely in AN than BN)^d</p>

Note. More information on the physical complications of anorexia nervosa is available in Birmingham CL, Beumont PJV: *Medical Management of Eating Disorders*. Cambridge, UK, Cambridge University Press, 2004. AN = anorexia nervosa; BN = bulimia nervosa; CT = computed tomography; DEXA = dual energy X-ray absorptiometry; ECG = electrocardiogram; EEG = electroencephalogram; EMG = electromyogram; fMRI = functional magnetic resonance imaging; MRI = magnetic resonance imaging; PET = positron emission tomography.

^aAnthropometrics estimate only peripheral fat. Underwater weighing assesses total body fat.

^bBecause QTc prolongation may be associated with sudden death, other medications known to prolong QTc intervals should generally be avoided and any electrolyte abnormalities (e.g., hypokalemia) and hypomagnesemia should be corrected if QTc prolongation is present. In anorexia nervosa, QTc intervals typically normalize with refeeding.

^cSome chronically ill patients have renal abnormalities associated with decreased urinary volume. Some drink excessive amounts of fluids to assuage hunger, producing increased urinary volume.

^dAlthough patients with bulimia nervosa who are of normal weight may not need extensive evaluation for osteopenia or osteoporosis, those who have had previous episodes of anorexia nervosa may be at higher risk for these abnormalities and require a similar assessment to that recommended for patients with anorexia nervosa.

→ **Assess and monitor the patient's psychiatric status, including co-occurring conditions and safety.**

- Determine whether the patient is at potential risk of self-harm.
 - Assess current suicidal ideation, plan, or intent, including access to means for suicide.
 - Obtain history of suicidal ideation, suicide attempts, and self-injurious behavior.
- Identify the presence of co-occurring psychiatric signs, symptoms, or conditions, including
 - mood symptoms and disorders,
 - anxiety symptoms and disorders,
 - obsessions/compulsions,
 - substance abuse,
 - impulsive behaviors (including shoplifting), and
 - personality disturbances.

→ **Assess family issues and enlist family support.**

- Identify any family history of eating disorders, other psychiatric disorders, and obesity.
- Assess family dynamics (e.g., guilt, blame) and attitudes toward eating, exercise, and appearance.
- Identify family reactions to the patient's disorder and the burden of illness for the family.

→ **Provide education about the patient's eating disorder and its treatment.**

- Give direct advice and information to the patient and to involved family members.
- Suggest resources such as self-help workbooks and community- and Internet-based information.
- Caution about potentially detrimental Internet sites that encourage eating-disordered lifestyles.

B. Treatment Goals

After establishing initial treatment goals, reassess and adjust them during the course of treatment.

Restore or maintain healthy weight.

- Estimate healthy weight for each individual patient.
- Base estimate on historical considerations (e.g., growth charts; for women, weight at which healthy menstruation and ovulation resume) and patient's individual characteristics (e.g., body build, body composition, other physiological variables).

Minimize food restrictions.

Reduce binge eating and purging behaviors, if present.

Provide education regarding healthy nutrition and eating patterns.

Encourage healthy but not excessive exercise.

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

B. Treatment Goals (continued)

→ **Address underlying themes and correct core maladaptive thoughts and attitudes:**

- 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

→ **Treat physical complications.**

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

→ **Provide family counseling and therapy where appropriate.**

→ **Prevent relapse.**

C. Treatment

1. Treatment Setting

→ **Determine an initial level of care or change to a different level of care based on an overall assessment of the patient.**

- Consider the patient’s physical condition (particularly weight and cardiac status), psychology, behaviors, and social circumstances. Also consider the availability of the appropriate level of care (e.g., consider constraints of geography or insurance).
- Avoid basing level of care determinations on a single or limited number of physical parameters, such as weight alone.
- Hospitalize *before* a patient becomes medically unstable. Use the patient’s general medical status to determine whether psychiatric or medical hospitalization is indicated.

→ **Consider inpatient hospitalization for patients with the following indications:**

Medical Indications

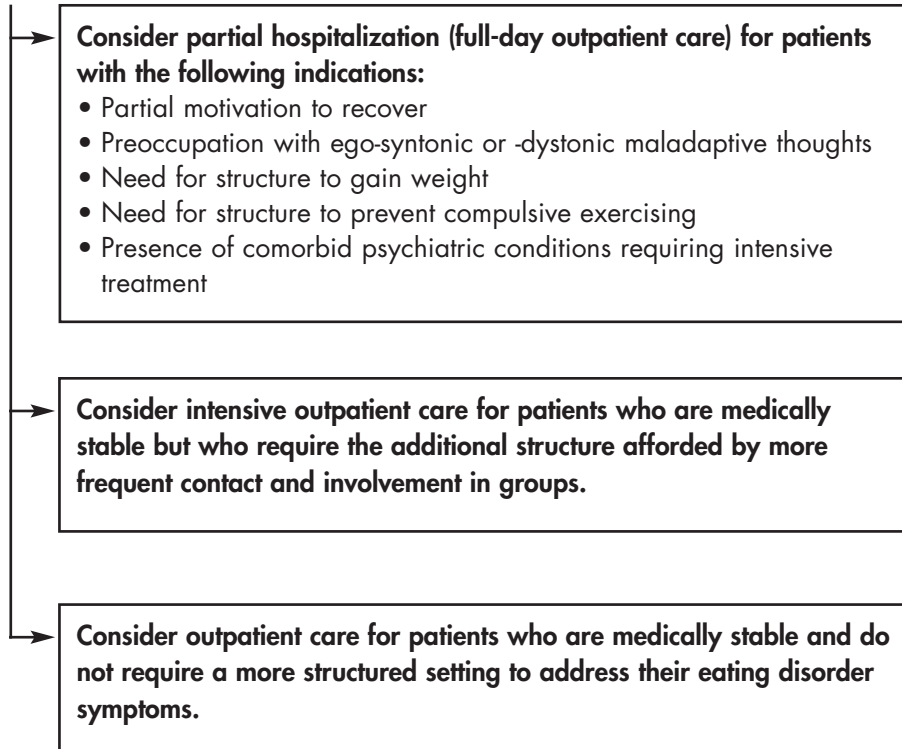
Adults	Children and Adolescents
<ul style="list-style-type: none"> • Generally, weight <85% of individually estimated healthy body weight • Heart rate <40 bpm • Blood pressure <90/60 mm Hg • Glucose <60 mg/dL • Potassium <3 mEq/L • Electrolyte imbalance • Temperature <97.0°F • Dehydration • Hepatic, renal, or cardiovascular organ compromise requiring acute treatment • Poorly controlled diabetes 	<ul style="list-style-type: none"> • Generally, weight <85% of individually estimated healthy body weight or acute weight decline with food refusal • Heart rate near 40 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, hypophosphatemia, or hypomagnesemia

1. Treatment Setting (continued)**Other Factors**

- Suicidal intent and suicide plan or other factors suggesting a high level of suicide risk
- Poor motivation to recover
- Preoccupation with ego-syntonic or -dystonic maladaptive thoughts
- Lack of cooperation with treatment or cooperation only in highly structured settings
- Any existing psychiatric disorder that would require hospitalization
- Severe co-occurring substance use disorder
- Need for supervision during and after all meals and in bathrooms
- Uncontrolled vomiting or hematemesis
- Presence of additional stressors interfering with the patient's ability to eat (e.g., intercurrent viral illnesses, significant psychosocial stressors or inadequate social supports)
- Weight near that at which medical instability occurred in the past
- Severe disabling symptoms of bulimia that have not responded to outpatient treatment

Consider a residential treatment center for patients with the following indications:

- Medical stability to the extent that intravenous fluids, nasogastric tube feedings, or multiple daily laboratory tests are not needed
- Generally, weight <85% of individually estimated healthy body weight
- Poor to fair motivation to recover
- Preoccupation with ego-syntonic or -dystonic maladaptive thoughts
- Cannot eat and gain weight by self; needs supervision at all meals to prevent restrictive eating
- Need for structure to prevent compulsive exercising
- Pronounced role impairment
- Severe family conflict or problems; absence of family, adequate support system, or both



2. Anorexia Nervosa
a. Nutritional Rehabilitation

- **Establish goals for seriously underweight patients:**
 - Restore weight.
 - Normalize eating patterns.
 - Achieve normal perceptions of hunger and satiety.
 - Correct biological and psychological sequelae of malnutrition.

- **Help the patient to resume eating and to gain weight.**
 - Establish a 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 begin intake at 30–40 kcal/kg per day (approximately 1,000–1,600 kcal/day); intake may be increased to as high as 70–100 kcal/kg per day.
 - Reserve nasogastric feeding for rare patients with extreme difficulty recognizing their illness, accepting the need for treatment, or tolerating guilt accompanying active eating even when done to sustain life.
 - 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); or other evidence of a serious refeeding syndrome.
 - Address gastrointestinal symptoms, particularly constipation, bloating, and abdominal pain.
 - Provide cardiac monitoring, especially at night, for children and adolescents who are severely malnourished.
 - Add vitamin and mineral supplements; for example, phosphorus supplementation may be particularly useful to prevent serum hypophosphatemia.
 - Create a milieu that incorporates emotional nurturance and a combination of reinforcers that link exercise, bed rest, and privileges to target weights, desired behaviors, and feedback concerning changes in weight and other observable parameters.

→ **Help the patient to maintain weight.**

- Once desired weight is achieved, calculate ongoing caloric intake based on weight and activity. For children and adolescents, intake levels at 40–60 kcal/kg per day are often needed for growth and maturation.
- Help the patient cope 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.

2. Anorexia Nervosa

b. Psychosocial Treatments

→ **Establish goals, including to help the patient**

- understand and cooperate with nutritional and physical rehabilitation,
- understand and change the behaviors and dysfunctional attitudes related to the eating disorder,
- improve interpersonal and social functioning, and
- address comorbid psychopathology and psychological conflicts that reinforce or maintain eating disorder behaviors.

→ **Establish and maintain a psychotherapeutically informed relationship with the patient.**

This includes understanding the following:

- Psychodynamic issues, including deficits in sense of self and interpersonal and intrapsychic conflicts
- Cognitive development
- Psychological defenses
- Complexity of family relationships
- Influence of other psychiatric disorders that may be present
- Patient preferences

2. Anorexia Nervosa

b. Psychosocial Treatments (continued)

→ Provide formal psychotherapy once weight gain has started.

Therapy	Indication/Notes
Individual psychotherapy	<p>Is usually required for at least 1 year and may take many years because of the enduring nature of the illness and the need for support during recovery.</p> <p>Cognitive-behavioral, interpersonal, and psychodynamic approaches—or a combination of these approaches—have the most evidence and consensus for use in adults.</p>
Family and couples therapy	<p>Is useful when family or marital problems are contributing to the maintenance of the disorder.</p> <p>Family approaches are most effective with children and adolescents, particularly with illnesses lasting less than 3 years.</p>
Group psychotherapy	<p>Typically has a cognitive-behavioral, interpersonal, and/or psychodynamic focus.</p> <p>Care must be taken to help patients avoid competition to be the thinnest or the sickest and cope with demoralization from observation of the difficult, chronic course of the illness.</p>
Self-help, online resources, and 12-step models	<p>Can be helpful adjuncts for some patients.</p> <p>Lack of professional supervision can sometimes perpetuate misinformation or unhealthy dynamics.</p>

2. Anorexia Nervosa

c. Medications

→ Use psychotropic medications in conjunction with psychosocial interventions, not as a sole or primary treatment for patients with anorexia nervosa.

→ Whenever possible, defer making decisions about medications until after weight has been restored.

→ Be aware of and manage general side effects.

- Malnourished, depressed patients are more prone to side effects.
- Cardiovascular consultation may be helpful if there is concern about potential cardiovascular effects of a medication.

→ Consider antidepressants to treat persistent depression or anxiety following weight restoration.

- Selective serotonin reuptake inhibitors (SSRIs) have the most evidence for efficacy and the fewest difficulties with adverse effects.
- SSRIs may also be useful in patients with bulimic or obsessive-compulsive symptoms.
- Bupropion should be avoided in patients with eating disorders because of increased risk of seizures.
- Tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) should be avoided in underweight patients; their potential lethality and toxicity in overdose should be taken into consideration.
- Clinicians should attend to the black box warnings in the package inserts relating to antidepressants and discuss the potential benefits and risks of treatment with patients and families if such medications are to be prescribed.

2. Anorexia Nervosa
c. Medications (continued)

Consider second-generation and low-potency antipsychotics for selected patients with severe symptoms.

- Evidence from controlled trials is limited. Clinical impression suggests these agents may be useful for patients with severe unremitting resistance to gaining weight, severe obsessional thinking, and denial that approaches delusional proportions.
- If these agents are used, monitor for side effects, including laboratory abnormalities.

Consider approaches to restore lost bone mineral density.

- Calcium supplementation should be considered when dietary calcium intake is inadequate for growth and maintenance.
- Vitamin D supplementation can be added in patients without daily sunlight exposure, but excessive doses should be avoided.
- Hormone replacement therapy is sometimes given, but there is no good evidence for efficacy and its use can enhance patient denial of illness by creating regularly occurring “pseudomenses” (pharmacologically induced menses).
- Biphosphonates such as alendronate are generally not indicated.

3. Bulimia Nervosa

a. Nutritional Rehabilitation

→ **Optimal weights should be determined and restored for all patients, since deviance from optimal weight may contribute to sustaining bulimia symptoms.**

→ **Provide nutritional counseling to help the patient**

- establish a pattern of eating regular, nonbinge meals,
- increase the variety of foods eaten,
- correct nutritional deficiencies,
- minimize food restriction, and
- encourage healthy but not excessive exercise patterns.

3. Bulimia Nervosa

b. Psychosocial Treatments

→ **Establish goals that include helping the patient to**

- reduce and, when possible, eliminate binge eating and purging,
- understand and cooperate with nutritional and physical rehabilitation,
- enhance motivation to cooperate in the restoration of healthy eating patterns and to participate in treatment,
- learn about healthy nutrition and eating patterns,
- reassess and change core dysfunctional thoughts, attitudes, motives, conflicts, and feelings related to the eating disorder, and
- improve interpersonal and social functioning.

→ **Other goals may include**

- enlisting family support and providing family counseling and therapy, when appropriate, and
 - treating associated psychiatric conditions, including deficits in mood and impulse regulation, self-esteem, and behavior.
- ↓

3. Bulimia Nervosa

b. Psychosocial Treatments (continued)

→ **Establish and maintain a psychotherapeutically informed relationship with the patient.**

This includes understanding the following:

- Psychodynamic issues that address conflicts, core sense of self, affect regulation
- Cognitive and psychological development
- Cognitive style and psychological defenses
- Complexity of family situation and relationships
- Influence of other psychiatric disorders that may be present
- Influence of transference and countertransference
- Patient preferences

→ **Provide psychotherapeutic interventions appropriate to the individual patient's development history, psychodynamic issues, cognitive style, comorbid psychopathology, preferences, age, and family situation.**

Psychotherapy may be needed on a long-term basis, particularly for patients with concurrent anorexia nervosa or severe personality disorders, although controlled studies have been short-term.

Therapy	Indication/Notes
Individual psychotherapy	
Cognitive-behavioral therapy	Is effective as a short-term intervention when specifically directed at eating disorder symptoms and underlying maladaptive cognitions. Is useful in reducing binge eating symptoms and improving attitudes about shape, weight, and restrictive dieting.
Interpersonal psychotherapy	May also be helpful.
Psychodynamically oriented and psychoanalytic approaches	May also be helpful.

Therapy	Indication/Notes
Individual psychotherapy (<i>continued</i>)	
Behavioral techniques (e.g., planned meals, self-monitoring)	May also be helpful.
Group psychotherapy	<p>May be based on cognitive-behavioral, interpersonal, psychodynamic, and/or supportive models.</p> <p>Can help the patient with shame surrounding the disorder.</p> <p>Provides peer-based feedback and support.</p> <p>Is more useful if dietary counseling and management are included in the program.</p>
Family and couples 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.
Self-help, online resources, and 12-step models	<p>Can be helpful adjuncts for some patients.</p> <p>Lack of professional supervision can sometimes perpetuate misinformation or unhealthy dynamics among users.</p>

3. Bulimia Nervosa
c. Medications

→ Consider an antidepressant to reduce the frequency of binge eating and vomiting, reduce associated symptoms (e.g., depression, anxiety, obsessions, impulsivity), and prevent relapse.

- For relapse prevention, most clinicians recommend continuation of the antidepressant for at least 9 months.
- The combination of psychotherapy and medication may be superior to either modality alone.
- 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.
- Clinicians should attend to the black box warnings in the package inserts relating to antidepressants and discuss the potential benefits and risks of treatment with patients and families if such medications are to be prescribed.

Class	Notes
SSRIs	<p>Have the most evidence for efficacy and the fewest difficulties with adverse effects.</p> <p>Helpful for depression, anxiety, obsessions, certain impulse disorder symptoms, and for those patients with a suboptimal response to appropriate psychosocial therapy.</p> <p>Fluoxetine is the only medication currently approved by the FDA for bulimia nervosa.</p> <p>Dosages may need to be higher than those used to treat depression (e.g., 60–80 mg/day of fluoxetine).</p> <p>Typical side effects include insomnia, nausea, asthenia, sexual side effects.</p>

Class	Notes
TCA's	Should generally be avoided, and their potential lethality and toxicity in overdose should be taken into consideration.
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.

For patients who require a mood-stabilizing medication (e.g., for co-occurring bipolar disorder), choose an agent that is most compatible with the patient's preferences and disordered behaviors.

- Weight gain associated with lithium and valproic acid can distress patients with eating disorders and result in nonadherence.
- Levels of lithium carbonate can shift markedly with rapid volume changes that accompany bingeing and purging.

4. Eating Disorders Not Otherwise Specified

a. Subsyndromal Eating Disorders

For patients with subsyndromal anorexia nervosa or bulimia nervosa, who meet most but not all of the DSM-IV-TR criteria, provide treatment similar to that provided for patients who fulfill all criteria.

4. Eating Disorders Not Otherwise Specified
b. Binge Eating Disorder

Provide nutritional rehabilitation.

- Behavioral weight control programs incorporating low- or very-low-calorie diets may help with weight loss and usually reduce symptoms of binge eating.
- Weight loss is often difficult to maintain, and binge eating can recur with weight gain.
- Obese binge eaters who primarily wish to lose weight should be treated with the same approaches as other obese individuals.

Provide psychosocial treatment.

- Cognitive-behavioral therapy has evidence for efficacy in individual and group formats as well as in self-help and guided self-help sequenced treatment programs.
- Interpersonal therapy and dialectical behavior therapy also have efficacy in treating behavioral and psychological symptoms.
- Other diets, behavior therapies, psychodynamic psychotherapy, and non-weight-directed psychosocial treatments are less well studied but may be of benefit for binge eating, weight loss, or stabilization in some patients.
- Self-help organizations and 12-step-based approaches have been tried, but no systematic outcome studies are available.

→ **Consider if the patient would benefit from an antidepressant or other medication.**

- Antidepressant treatment is associated with short-term reductions in binge eating but generally does not result in substantial weight loss.
- SSRIs have the fewest difficulties with adverse effects and the most evidence for efficacy when used at the high end of the recommended dosage range.
- Sibutramine, an appetite suppressant medication, is effective for binge suppression in the short-term and can produce significant weight loss.
- Topiramate, an anticonvulsant, can reduce bingeing and decrease weight, but its use may be limited by side effects.

→ **Consider if the patient would benefit from the combination of psychotherapy and pharmacotherapy.**

Although limited evidence is available, combined treatment is frequently used in clinical practice.

