

# Eating Disorders Clinical Guidelines

Developed in collaboration with the mental health centers associated with NBHP and FBHP

DSM-IV-TR Diagnostic Codes: 307.1, 307.51, 307.50

## Diagnostic Considerations:

1. **Review diagnostic criteria** in DSM-IV-TR. The DSM-IV-TR defines two sub-diagnoses within the eating disorder spectrum: Anorexia Nervosa and Bulimia Nervosa. Main themes of these disorders include:

- Severe disturbance in eating behavior
- Disturbance in perception of body shape and weight
- Refusal to maintain a minimally normal body weight (Anorexia Nervosa)
- Repeated episodes of binge eating followed by inappropriate compensatory behaviors such as self-induced vomiting (Bulimia Nervosa)

Each disorder contains two sub-types to clarify the presence of purging behaviors:

- Restricting and Binge-Eating/Purging Type (Anorexia Nervosa)
- Purging and Non-Purging Type (Bulimia Nervosa)

2. **Anorexia Nervosa** affects about .5% of the population. Of the cases that are reported, 90% are female. Typical onset is mid to late adolescence (14-18 years), and may be precipitated by a stressful life event. The course of illness is variable, and could result in a single episode, cyclical pattern or chronically-deteriorating progression. This disorder is highly heritable, and influenced by both genetics and the learning environment.
3. **Bulimia Nervosa** is reported by approximately 1-3% of the population, with 90% female as well. Typical onset is late adolescence or early adulthood, and often during or after dieting. The course tends to be either chronic or intermittent, and long term studies indicate that symptoms usually decrease over time. Frequency of Bulimia increases when there is a family history of Bulimia, mood disorders or substance abuse.
4. **Consider differential and co-occurring diagnoses** including: general medical conditions, personality disorders (specifically Borderline Personality Disorder), anxiety disorders (specifically Obsessive-Compulsive Disorder and Social Phobia), Major Depressive Disorder, and Body Dysmorphic Disorder. Co-occurring substance use disorders should also be considered, as the presence of substance abuse can complicate treatment.
5. **Clinical assessment** can include screening tools such as the Eating Attitudes Test (EAT or EAT-26) and Sick, Control, One, Fat, Food Questionnaire (SCOFF) diagnostic measures such as the Eating Disorder Examination (EDE) and The Interview for the Diagnosis of Eating Disorders- IV (IDED-IV), as well as measures for treatment planning and evaluation such as the Multifactorial Assessment of Eating Disorder Symptoms (MAEDS), Eating Disorder Inventory-3 (EDI-3), and the Body Shape Questionnaire (BSQ). Other tools may be used to rule out differential diagnoses. (See assessment resources below for links to assessments and more information)
6. **Complete psychosocial assessment**, including social and family history, can identify potential precipitating factors: interpersonal relationships/conflicts, family history of eating disorders or other mental health or substance abuse diagnoses, trauma history, stressful life events, criticism towards body shape/size, atypical dieting or obsessive-compulsive symptomology regarding food, overprotective/demanding family structures, self-punishing or harming behaviors, and activities during childhood that focus on weight and/or slimness. Assess details of symptomology, including

detailed report of food intake during a single day, bingeing and purging behaviors throughout the day; and triggering emotions, behaviors, and thoughts, such as obsessional thoughts related to body image, weight gain, eating, and general self-esteem. Previous episodes of eating disorder and response to treatment should also be assessed.

7. **Assess for stage of change.** Readiness for change can significantly impact treatment process and outcomes and will help determine the first course of treatment.
8. **Evaluate risk for self-harm,** including self-harming behaviors, suicidal ideation, plan or intent. Assess history of suicide attempts, as well as dynamic factors such as psychosocial stress, substance use, and means of harm.
9. **Cultural factors** can affect the development and presentation of eating disorders, including cultural norms portrayed in social environments and media related to body size and shape. Consider how these cultural expectations and models influence the client.

#### **Treatment Guidelines:**

1. **Collaborate with medical providers** regarding the client's physical health. Ensure client has had a recent, full physical examination, paying particular attention to vital signs, BMI, blood chemistry, cardiovascular functioning, bone density, and muscular weakness. Numerous medical complications can result from eating disorders and it is important that all providers are aware of the eating disorder, the physical consequences, and the importance of collaboration. Provide referrals to and collaborate with nutritionists who have expertise in eating disorders. For clients with purging behavior, ensure recent dental exam as well.
2. **Determine level of care and appropriateness of treatment setting.** If medically necessary or if client is significantly underweight, it may be necessary to refer for inpatient care until adequate weight has been restored and medical complications are stable. Ongoing inpatient care, beyond medical stabilization, has not been supported by the literature.
3. **Provide education** about eating disorders, the physical consequences that may result for eating disorder behaviors, and treatment. Suggest resources such as educational materials or self-help workbooks, as well as community support groups that may be appropriate for clients and their families (see "Tips" sheet for resources). Particularly for children and adolescents, caution families about internet sites that can be harmful by encouraging eating-disordered behavior.
4. **Medications can supplement therapy** where appropriate. Refer for psychiatric evaluation and consult with prescriber regularly. It is generally recommended to avoid beginning medication until weight is stabilized. SSRI's have been most supported by clinical trials for effectiveness with Bulimia and Anorexia, especially where depression and/or anxiety is co-occurring. Second generation antipsychotics may be used for some clients with severe symptoms.
5. **Be patient in developing a trusting therapeutic relationship** as this may take time. A trusting relationship is a key factor in motivating change. Encourage client choice, as control is a prominent underlying issue for many clients with eating disorders. Engage clients in treatment planning and help them to identify areas in their lives where they have control or would like more healthy control.

6. **Motivational Interviewing** has demonstrated promising results in some studies and may be indicated during initial phases of treatment when motivation is low. This technique has been found to be particularly effective with Anorexia.
7. **Cognitive Behavioral Therapy and Interpersonal Therapy** are the most widely researched therapeutic approach for the treatment of eating disorders, particularly with Bulimia. The research on effective treatment of Anorexia remains slim. The goals of effective CBT and Interpersonal therapy involve identify underlying themes and core maladaptive thoughts: developmental issues, identity formation, perceived lack of control, body image concerns, self-esteem, sexual issues and aggression, affect regulation, gender role expectations, family dysfunction and family expectations, perfectionism, and coping styles. It is important to disrupt the binge-purge cycle for bulimia using cognitive behavioral strategies, paying particular attention to the role of guilt and shame in maintaining obsessive-compulsive behaviors. Once the client is stable, the final stage of treatment involves planning for relapse prevention.
8. **Mindfulness-based CBT approaches**, such as DBT and others have shown effectiveness and are promising practices for the treatment of Anorexia.
9. **Family Therapy** for children and adolescents is strongly recommended, such as the Maudsley Approach (Lock et al., 2001), where parents are active in the treatment and recovery, or modified versions of this method. Involvement of partners/spouses of adult clients may be useful as well. In many cases, short term therapy (10 sessions) has proven just as effective as longer term therapy (20 sessions), unless complicating factors exist, such as co-occurring Axis I or personality disorders.
10. **Treatment providers** should have adequate training for the treatment of eating disorders. Seek supervision, consultation, or additional training if needed before beginning treatment. Be aware of community supports and additional resources or referrals to support clients' treatment needs.

### References and Resources

American Psychiatric Association, Practice guidelines for the treatment of patients with eating disorders, third edition (2006), update added

2012 <http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1671334>

American Psychiatric Association [www.healthyminds.org](http://www.healthyminds.org)

Anderson, D.A., Lundgren, J.D., Shapiro, J.R., Paulosky, C.A. (2004) Assessment of eating disorders: Review and recommendations for clinical use. *Behavior Modification*, 28(6), 763-782

Eating disorders: A transdiagnostic protocol. Fairburn, Christopher G.; Cooper, Zafra; Shafran, Roz; Wilson, G. Terence. In Barlow, David H. (Ed), (2008). *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed.), (pp. 578-614). New York, NY, US: Guilford Press, xiv, 722 pp. 578-614.

Lock, J., Le Grange, D., Agras, W.S., Dare, C. (2001) *Treatment Manual for Anorexia Nervosa: A Family-Based Approach*. New York: The Guilford Press.

National Eating Disorders Association [www.nationaleatingdisorders.org](http://www.nationaleatingdisorders.org)

National Association of Anorexia Nervosa and Associated Disorders [www.anad.org](http://www.anad.org)

**Assessment Resources:**

- Eating Attitudes Test with Scoring and interpretation- <http://www.eat-26.com/downloads.php>
- SCOFF (Link to assessment) <http://www.healthyplace.com/psychological-tests/scoff-test/>
- SCOFF (Article about the assessment)- <http://www.bmj.com/content/319/7223/1467>
- EDE- [http://www.mentalhealthuk.org/pdf/EDE\\_16.0.pdf](http://www.mentalhealthuk.org/pdf/EDE_16.0.pdf)
- IDED-IV: Copyright: Vesna Kutlesic: University of New Mexico Health Sciences Center, Children's Psychiatric Hospital, 1001 Yale Boulevard, NE, Albuquerque, New Mexico, 87131.
- EDI-3 <http://www4.parinc.com/Products/Product.aspx?ProductID=EDI-3>
- BSQ (for general information) <http://www.psychtc.org/tools/bsq/>
- BSQ (link to assessment) [www.psychtc.org/tools/bsq/doc/bsq-34.do](http://www.psychtc.org/tools/bsq/doc/bsq-34.do)