Guideposts for the Treatment of Eating Disorders

Optum is committed to assuring our members receive the highest quality evidence based and person-centered care available. Optum recognizes the time demand on staff and providers and offers this resource to give rapid access to evidence based strategies and guidance from professional organizations. These key components from several best practice guidelines will serve as a common language among Optum, providers and members that allows us to all work together in a member-centric manner. We want to partner to provide the highest quality care to our members.

Assessment:

1. **When assessing for an eating disorder or deciding whether to refer people for assessment, take into account any of the following that apply:**
    - **an unusually low or high body mass index (BMI) or body weight for their age**
    - **rapid weight loss**
    - **dieting or restrictive eating practices (such as dieting when they are underweight) that are worrying them, their family members or caregivers, or professionals**
    - **family members or caregivers report a change in eating behavior**
    - **social withdrawal, particularly from situations that involve food**
    - **other mental health problems**
    - **a disproportionate concern about their weight or shape (for example, concerns about weight gain as a side effect of contraceptive medication)**
    - **problems managing a chronic illness that affects diet, such as diabetes or coeliac disease**
    - **menstrual or other endocrine disturbances, or unexplained gastrointestinal symptoms**
    - **physical signs of: —malnutrition, including poor circulation, dizziness, palpitations, fainting or pallor —compensatory behaviors, including laxative or diet pill misuse, vomiting or excessive exercise**
    - **abdominal pain that is associated with vomiting or restrictions in diet, and that cannot be fully explained by a medical condition**
    - **unexplained electrolyte imbalance or hypoglycemia**
    - **atypical dental wear (such as erosion)**
    - **whether they take part in activities associated with a high risk of eating disorders (for example, professional sport, fashion, dance, or modelling). (NICE; Eating disorders: recognition and treatment, 2017).**
2. **Lab assessment including:**
    - **CBC, CMP, electrolytes, liver enzymes, renal function tests.**
    - **EKG with restrictive eating disorder and severe purging behaviors.**
    - **Serum amylase levels, of salivary amylase may be elevated in individuals with self-induced vomiting.**

- **If refeeding syndrome is suspected, serum levels of phosphorus, magnesium, potassium, and calcium should be determined until stabilized.**
- **Evaluation of possible co-occurring health conditions and also co-occurring psychiatric disorders. (Gerd, IBS, gastroparesis, G.I. motility disorders, diabetes, celiac disease, inflammatory bowel disease). (Depression, anxiety, OCD, history of trauma).**
  (APA; The American Psychiatric Association Practice Guideline for the Treatment of Patients with Eating Disorders, 2023)

Treatment:

3. **Identify a treatment goal weight. (AAP, Identification and Management of Eating Disorders in Children and Adolescents, 2021)**
4. **In working to achieve target weights, the treatment plan should also establish expected rates of controlled weight gain. Consensus suggests that realistic targets are:**
   - **2 – 4 pounds/week inpatient or RTC programs.**
   - **1 – 3 pounds/week PHP programs.**
   - **1 – 2 pounds/week outpatient programs.**

   Data from both inpatient and outpatient settings indicate that early weight gain and faster rate of weight gain are associated with better outcomes.
   - **Many programs now using higher initial caloric prescriptions (1500 – 2000 cal/day) and faster rates of re-nourishment as literature has not shown association with development of refeeding syndrome. As weight restoration proceeds, daily caloric intake should be gradually increased, with most individuals requiring between 3000 – 4000 cal/day to achieve regular rate of weight gain. (APA)**
5. **Outpatient psychosocial interventions are the initial treatment of choice for children and adolescents with eating disorders.**
   - **Family Based Therapy (FBT-Maudsley Family Therapy) is effective and superior to comparison individual therapies.**
   - **Adolescent-Focused Therapy (AFT) and Cognitive Behavioral Therapy (CBT) has also been found to be effective for those who do not meet full criteria for these disorders.**

   (AACAP; Identification and Management of Eating Disorders in Children and Adolescents | Pediatrics | American Academy of Pediatrics (aap.org); 2015)

Support:

6. **Develop a care plan for each person with an eating disorder who is admitted to inpatient care. The care plan should:**
   - **give clear objectives and outcomes for the admission**
   - **be developed in collaboration with the person, their family members or caregivers (as appropriate), and the community-based eating disorder service**
   - **set out how they will be discharged, how they will move back to community-based care, and what this care should be. (NICE)**
7. **Understanding the individual's cultural identity. Cultural and religious beliefs can be relevant to dietary choices. (APA)**

Recovery:

8. **Adults with bulimia nervosa can be treated with eating disorder focused CBT (CBTe) and SSRI medication can also be prescribed, either initially, or if there is minimal or no response to psychotherapy alone by six weeks of treatment. Use of buproprion (Wellbutrin) is contraindicated in patients with purging behaviors or history of purging behaviors due to the increased risk of seizures. (APA)**
9. **First line treatment for binge eating disorder is eating disorder focused CBT (CBTe) or interpersonal therapy (IPT), in either individual or group format. Adults who prefer medication, or have not responded to psychotherapy alone, can be treated with antidepressant medication or Vyvanse. (APA)**

Guideposts Details

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    - **whether they take part in activities associated with a high risk of eating disorders (for example, professional sport, fashion, dance, or modelling).**

    (NICE; Eating disorders: recognition and treatment, 2017).

Background Information:

Consensus has shown when evaluating for a possible eating disorder medical stability is the top priority. Eating disorders are serious disorders and can be life threatening. One must be evaluated for medical emergencies and whether hospitalization is indicated. Self-report,

collateral history, and clinical signs may indicate underlying clinical conditions such as amenorrhea, arrhythmia, bradycardia, brittle hair/nails, edema, hypotension, hypothermia, lanugo, osteoporosis, dental erosions, parotid gland enlargement and weight fluctuations.

"Primary care providers have a unique opportunity to assess for eating disorders in their patient's annual well-child appointments by pediatricians/adolescent medicine specialists, sports and camp health assessments for youth, and comprehensive psychiatric evaluations provide the opportunity to monitor for eating disorder risk and symptoms. APA recommends screening as part of every comprehensive psychiatric evaluation, and AAP and SAHM guidelines recommend screening for individuals at risk for eating disorders. An eating disorder should be suspected in the presence of significant weight changes outside the expectations based on their growth charts and family history, including rapid weight gain, weight loss or failure to gain weight in an adolescent (e.g., falling off their growth curve), or the presence of disordered eating behaviors such as restricting (quantity, frequency, and/or variety), purging (vomiting, laxative abuse, compulsive exercise), or binge eating. Amenorrhea, over-exercise injuries (e.g., stress fractures), lab abnormalities (e.g., potassium), low resting heart rate (HR < 50), and swelling around the cheeks and jaw should also be evaluated in the context of a possible eating disorder. Eating disorders rise in proportion to the level of food insecurity in a community, and patients experiencing this should be paid particular attention."*

BMI may not be diagnostically helpful, and target weight range should consider historic growth curves and in adolescents, onset and tempo of puberty (Kennedy Forum, 2023).

2. **Lab assessment including:**
    - **CBC, CMP, electrolytes, liver enzymes, renal function tests.**
    - **EKG with restrictive eating disorder and severe purging behaviors.**
    - **Serum amylase levels, of salivary amylase may be elevated in individuals with self-induced vomiting.**
    - **If refeeding syndrome is suspected, serum levels of phosphorus, magnesium, potassium, and calcium should be determined until stabilized.**
    - **Evaluation of possible co-occurring health conditions and also co-occurring psychiatric disorders. (Gerd, IBS, gastroparesis, G.I. motility disorders, diabetes, celiac disease, inflammatory bowel disease). (Depression, anxiety, OCD, history of trauma).**

    (APA; The American Psychiatric Association Practice Guideline for the Treatment of Patients with Eating Disorders, 2023)

Background Information:
Life threatening complications of eating disorders can be discovered via laboratory testing, helping to identify the degree of compromise. Electrolyte disturbances are common in those who are inducing emesis, abusing laxatives or diuretics. Most complications are due to the effects of malnutrition.

integratedcareclinic.com/blog/the-eating-disorder-medical-test-and-nutrition-lab-guide/ outlines definitions and why each lab is important.

Treatment:

3. **Identify a treatment goal weight.**
   (AAP, Identification and Management of Eating Disorders in Children and Adolescents, 2021)

Background Information:
The goal weight may be determined in collaboration with a registered dietitian. Acknowledging that body weights naturally fluctuate, the treatment goal weight is often expressed as a goal range. Individualized treatment goal weights are formulated based on age, height, premorbid growth trajectory, pubertal stage, and menstrual history.

"For patients who have fallen off of their growth curves, weight restoration via nutritional rehabilitation (increased quantity, frequency, and or variety of caloric consumption) is prioritized to restore both physical and mental health. For patients with binge-eating episodes (seen in both binge-eating disorder (BED), bulimia nervosa, and anorexia nervosa-binge/purge type), normalization of eating behaviors (i.e., eating 3 meals and 1-3 snacks per day) is prioritized to cease the restricting episodes that often precede binge eating behaviors. Lastly, behavioral interventions are used to implement the medical/nutritional interventions, and to help patients learn to resist the urges to engage in eating disorder behaviors like restricting, binge eating, and or compensatory behaviors such as compulsive exercise or purging. Psychological improvement is expected to follow behavioral and medical improvements."*

4. **In working to achieve target weights, the treatment plan should also establish expected rates of controlled weight gain. Consensus suggests that realistic targets are:**
   - **2 – 4 pounds/week inpatient or RTC programs.**
   - **1 – 3 pounds/week PHP programs.**
   - **1 – 2 pounds/week outpatient programs.**

   Data from both inpatient and outpatient settings indicate that early weight gain and faster rate of weight gain are associated with better outcomes.
   - **Many programs now use higher initial caloric prescriptions (1500 – 2000 Cal/day) and faster rates of re-nourishment as literature has not shown Association with development of refeeding syndrome. As weight restoration proceeds, daily caloric intake should be gradually increased, with most individuals requiring between 3000 – 4000 cal/day to achieve regular rate of weight gain. (APA)**

Background Information:
Various information in the literature suggests that the risk of refeeding syndrome may be overblown compared to early eating disorder literature.
A normal requirement for females is 2000 Cal/day and for males is 2200 Cal/day to maintain body weight.

5. **Outpatient psychosocial interventions are the initial treatment of choice for children and adolescents with eating disorders.**
   - **Family Based Therapy (FBT-Maudsley Family Therapy) is effective and superior to comparison individual therapies.**

- **Adolescent-Focused Therapy (AFT) and Cognitive Behavioral Therapy (CBT) have also been found to be effective for those who do not meet full criteria for these disorders.**

(AACAP; Identification and Management of Eating Disorders in Children and Adolescents | Pediatrics | American Academy of Pediatrics (aap.org); 2015)

Background Information:

"Guidelines indicate that for most individuals with eating disorders, outpatient treatment is the most appropriate first-line treatment. They should be treated in the least restrictive and least invasive treatment setting that can appropriately address any medical and co-occurring needs. Outpatient treatment allows families to be involved in treatment, patients to remain in their communities and avoids them missing out on important educational and social milestones. For some adolescents, medical stabilization, or behavioral supervision in a higher level of care may be necessary."*

Family-based treatment (FBT) Maudsley approach most effective therapy for treatment of anorexia nervosa in children and adolescents. Emerging evidence is starting to show effective use of CBT in adults with anorexia nervosa**. "**FBT has the strongest evidence base for treating adolescents and young adults with Anorexia Nervosa (AN) and Bulimia Nervosa (BN). All professional organizations recommend family-based treatment (FBT) for adolescents with AN or BN. FBT may also need to be adapted for higher levels of care when such levels of care are indicated. Emerging evidence suggests that FBT-approaches may be helpful in ARFID and BED as well. Cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT) are useful add-ons for older adolescents and young adults who have the capacity for articulating their cognitions associated with disordered eating behaviors, and should be used when needed, and especially when a family is unable to participate in treatment. Having a support system of healthy adults to participate in treatment, regardless of the specific intervention, is essential."*

Support:

6. **Develop a care plan for each person with an eating disorder who is admitted to inpatient care. The care plan should:**
    - **give clear objectives and outcomes for the admission**
    - **be developed in collaboration with the person, their family members or caregivers (as appropriate), and the community-based eating disorder service**
    - **set out how they will be discharged, how they will move back to community-based care, and what this care should be. (NICE)**

Background Information:

Inpatient treatment should be utilized for individuals who are significantly underweight or medically compromised. Setting clear goals and engaging supports is essential for improving outcomes.

"Families need increased physical and financial access to eating disorder treatment. Approximately 80% of people with eating disorders do not currently have access to recommended treatments. Barriers include lack of screening/identification, out-of-pocket cost, inadequate insurance coverage (e.g., level of care exclusions, dietitian session limits), lack of

availability and/or diversity among eating disorder treatment providers, weight stigma in acuity assessment, and inaccessibility of evidence-based treatment."*

7. **Understanding the individual's cultural identity. Cultural and religious beliefs can be relevant to dietary choices. (APA)**

Background Information:
A careful history might be needed from the patient and collateral sources to identify long-standing cultural or religious practices related to food, as compared to recent restrictions in food choice with onset of eating disorder.

"Culturally competent, multidisciplinary care teams are recommended for outpatient ED treatment. Eating disorders are multi-system illnesses that often require multidisciplinary care. Team members may include a mental health provider, a medical provider, psychiatrist, and/or a registered dietitian. Additionally, as stated in the SAHM and APA guidelines, providers should represent the diverse backgrounds and identities of patients with eating disorders and/or providers should be trained in culturally competent and humble care, particularly for BIPOC and LGBTQ+ individuals who face systemic barriers in diagnosis, treatment access, and recovery."*

Recovery:

"Recovery from an eating disorder takes both time and consistency. Once nutritional rehabilitation is complete, weight restoration is sustained for three months and eating disorder behaviors (e.g., restricting, purging, body checking, binge eating) have ceased, most individuals with eating disorders need continued treatment for the cognitive symptoms - such as body dysmorphia, anxiety and/or guilt around food and/or their body, and triggers and urges to engage in eating disorder behaviors - along with eating disorder-informed treatment for unresolved or long-term comorbidities as a best-practice for relapse prevention. Relapse rates following acute treatment are high, which may result from inadequate treatment following the acute phase."*

8. **Adults with bulimia nervosa can be treated with eating disorder focused CBT (CBTe). SSRI medication can also be prescribed, either initially, or if there is minimal or no response to psychotherapy alone by six weeks of treatment. Use of buproprion (Wellbutrin) is contraindicated in patients with purging behaviors or history of purging behaviors due to the increased risk of seizures. (APA)**

Background Information:
Of the SSRIs, fluoxetine (Prozac) up to 60 mg daily is the preferred choice because it has the greatest strength of research showing efficacy. APA recommends that adolescents and emerging adults with bulimia nervosa who have an involved caregiver receive eating disorder family-based treatment (FBT). APA also recommends caregiver education aimed at normalizing eating behaviors, weight control, and restoring weight (if indicated).

9. **First line treatment for binge eating disorder is eating disorder focused CBT (CBTe) or interpersonal therapy (IPT), in either individual or group format. Adults who prefer medication, or have not responded to psychotherapy alone, can be treated with antidepressant medication or Vyvanse. (APA)**

Background Information:

Of the SSRIs, fluoxetine up to 80 mg daily is the preferred choice because it has the greatest strength of research showing efficacy. The United States Food and Drug Administration (FDA) approved lisdexamfetamine dimesylate (Vyvanse) for adults with moderate to severe binge eating disorder in 2015. Vyvanse was the first of its kind prescription drug specifically indicated for binge eating disorder.

Sources:

- **APA**: The American Psychiatric Association; Practice Guideline for the Treatment of Patients with Eating Disorders; 2023
- **AACAP**: American Academy of Child and Adolescent Psychiatry; Practice parameter for the assessment and treatment of children and adolescents with eating disorders; 2015
- **AAP**: American Academy of Pediatrics; Identification and Management of Eating Disorders in Children and Adolescents; 2021
- **NICE**: National Institute for Health and Care Excellence; Eating Disorders: Recognition and Treatment, 2017
- **SAHM**: Society for Adolescent Health and Medicine. Medical Management of Restrictive Eating Disorders in Adolescents and Young Adults. J Adolesc Health Off Publ Soc Adolesc Med. 2022;71(5):648-654. doi:10.1016/j.jadohealth.2022.08.006

*Statements excerpted from: The Kennedy Forum (2023). *Eating Disorders Treatment Practice Guidelines: A Summary Statement for Children, Adolescents, and Young Adults*. Unpublished report thekennedyforum.org/.