***Note**: Our teams are working on a more robust section on Eating Disorders on our website. This PDF is meant to be a temporary resource, please check back often for the updated Eating Disorder Toolkit on childrenswi.org.*

PEDIATRIC EATING DISORDER TOOLKIT – MENTAL HEALTH PROVIDERS

This pediatric eating disorder toolkit, is intended as a resource for Registered Dietitians, Mental Health Providers, and Medical Providers that are seeing patients with eating disorders due to a lack or limited availability of specialized treatment providers available to patients/families. This is not a comprehensive treatment guide. The goal of this pediatric eating disorder toolkit is to promote key areas of assessment and follow up care until more specialized care is established. Please note that if specialized eating disorder care providers exist in or near your community, it is recommended to connect patients and families to these resources as quickly as possible.

Contributing Members:

Medical College of Wisconsin:

Samantha Everhart, PhD

Margaret Thew, DNP, FNP-BC

Children's Wisconsin Clinical Nutrition:

Ava Ajlouny, RD, CD

Becky Schmechel, RD, CD, CEDS-C

Sydney Tennies, RD, CD

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General Information

MULTIDISCIPLINARY TREATMENT TEAM

Treating eating disorders happens best under the guidance of a multidisciplinary treatment team:

- Primary medical provider
- Mental health therapist (LPC, LCSW, Psychologist), preferably trained in eating disorders
- Registered dietitian (RD), preferably trained in eating disorders
- Family therapist (if recommended)
- Psychiatrist (if recommended)

It is imperative that each member of the treatment team be willing and able to collaborate care with the other disciplines in a timely manner to ensure the best and most consistent care across all disciplines.

Unfortunately, sometimes it is not possible for all treatment team members to be part of the care team. This can be for a variety of reasons such as:

- Lack of providers in a specific geographic area.
  - If there is a lack of providers in your geographic area, please investigate virtual resources or referrals for your patients. There are many excellent virtual resources that could be assembled to form a full treatment team. Another great option is getting case consultation from a certified eating disorder specialist in that particular discipline. To connect with a Certified Eating Disorder Specialist visit the International Association of Eating Disorder Professionals website at iaedp.com and click on the link "Find An Eating Disorder Professional".
- Lack of insurance coverage for a particular specialty area.
  - It is advised that patients/families check with their health insurance company on coverage for each of these specialty areas for the treatment of an eating disorder.
- Patient/family may not want a particular discipline added to their loved ones' treatment team.
  - This can be for a variety of reasons. We encourage this be reviewed on a case-by-case basis. In most instances a full treatment team offers the best outcomes.

DIAGNOSTIC CRITERIA

Diagnosis of an eating disorder can be made by a medical provider, therapist, psychologist, or psychiatrist. These diagnostic criteria are provided for educational purposes. Please refer patient to an evaluation with a specialist if there are concerns for restricted or avoidant eating. For a complete listing (along with criteria) for feeding and eating disorders, please refer to DSM-5 (Diagnostic and Statistical Manual of Mental Disorders).

Avoidant Restrictive Food Intake Disorder (ARFID)

Avoidant/restrictive food intake disorder (ARFID) includes restrictive eating due to one or more of the following:

- Low appetite and lack of interest in eating or food.
- Extreme food avoidance based on sensory characteristics of foods e.g. texture, appearance, color, smell.
- Anxiety or concern about consequences of eating, such as fear of choking, nausea, vomiting, constipation, an allergic reaction, etc.

The diagnosis of ARFID requires that difficulties with eating are associated with one or more of the following:

- Significant weight loss (or failure to achieve expected weight gain in children).
- Significant nutritional deficiency.
- The need to rely on a feeding tube or oral nutritional supplements to maintain sufficient nutrition intake.
- Interference with social functioning (such as inability to eat with others).

Note: Consider SLP and/or OT referral when there are swallowing and/or sensory concerns.

Anorexia Nervosa

Anorexia nervosa includes the following symptoms:

- Caloric restriction leading to underweight OR weight that is less than what is expected for age.
- Intense fear of gaining weight OR persistent behavior that interferes with weight gain.
- Body image disturbance OR undue influence of body weight or shape on self-evaluation, OR lack of recognition of seriousness of low body weight.

Atypical Anorexia Nervosa

Atypical anorexia has the same criteria as anorexia nervosa with the exception of a BMI that is normal to above normal ranges despite significant weight loss.

Bulimia Nervosa

- Recurrent episodes of binging and purging at least once per week (purging may include self-induced vomiting, fasting, excessive exercise, laxative or diuretic misuse).

Binge Eating Disorder

- Discrete episodes of binge eating that occur at least once per week for 3 months.
- Episodes must include eating more than another person would in similar circumstances, and sense of loss of control.
- Episode have at least one of the following features: eating in secrecy, eating rapidly, eating until uncomfortably full, eating when not hungry, or guilt/shame afterward.

SYMPTOMS

Source of information: National Eating Disorders: https://www.nationaleatingdisorders.org/warning-signs-and-symptoms. Please note: this is *not* a checklist but instead a list of symptoms that could be present with some eating disorders.

- Preoccupation with dieting/fad dieting, weight or weight loss, body shape and size
- Frequent mirror checking for perceived appearance flaws
- Preoccupation with food or food avoidance, calories, carbohydrates, sugar, fat
- Overly strict food rules
- Refusal to eat certain foods or up to whole food groups, or foods previously enjoyed
- Cutting out an increasing number of foods or food groups
- Increased concern and time spent thinking about "health" of ingredients, what is deemed "health, clean, or pure", high distress when healthy foods aren't available, follow and fixated on health/clean eating
    - For more information, search **ORTHOREXIA** on the National Eating Disorders website
- Withdrawal from friends/family, no longer participating in things use to enjoy doing
- Eating/behavior rituals with eating (certain utensils, certain order of eating, slow/fast eating pace, preference to eat alone)
- Excessive or rigid exercise regime (despite weather, sickness, injury, fatigue), need to 'burn' or get rid of calories, intense feelings if unable to exercise, exercise used to manage emotions, discomfort with rest or inactivity, exercise for permission to eat, exercising in secret, intense feelings involving physical activity
- Feelings of disgust, shame, guilt overeating, low self-esteem
- Eating of non-food items
- Small portions or skipping meals
- Gastrointestinal concerns (constipation, diarrhea, vomiting, acid reflux, bloating, stomach cramping, getting full quickly)
- Menstrual irregularities (light, inconsistent, irregular, amenorrhea, missing periods without the use of hormone contraceptives)
- Growth chart percentile changes, weight fluctuations
- Mood swings, difficulty concentrating, feelings of disgust, shame, guilt over eating, low self-esteem, withdrawal from friends and or family, depression and/or anxiety
- Low appetite, limited preferred foods, and lack of interest in eating or food. Extreme food avoidance based on sensory characteristics of foods e.g. texture, appearance, color, smell. Anxiety or concern about consequences of eating, such as fear of choking, nausea, vomiting, constipation, an allergic reaction, etc.

MEDICAL FINDINGS

Please note: this is *not* a checklist but instead a list of medical findings that could be present with some eating disorders.

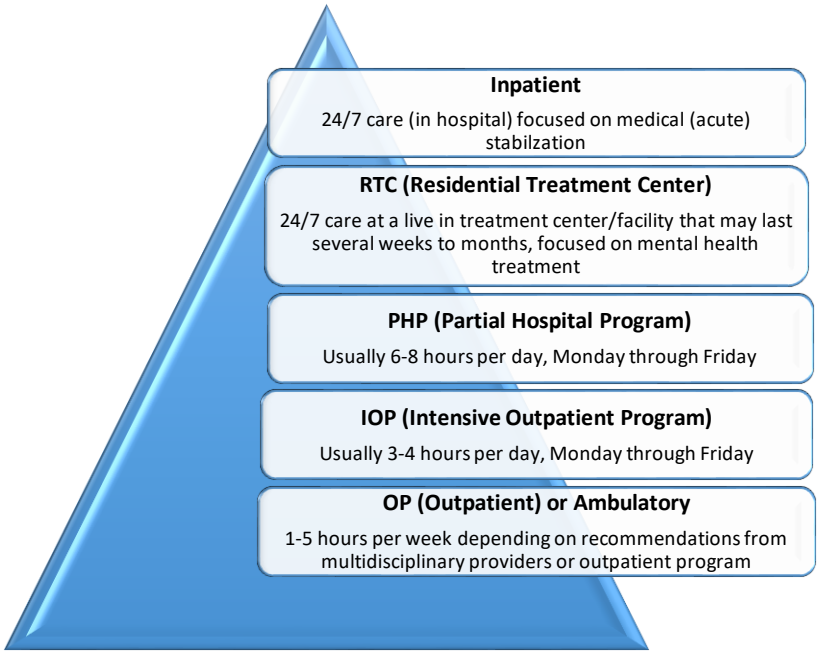
- Orthostatic intolerance symptoms, lightheadedness, dizzy upon standing, fainting
- ECG, bradycardia, irregular heart patterns
- Muscle weakness
- Cold intolerance (feeling cold all the time, extremities cold and mottled, dressing in layers-can also be to hide weight loss or self-harm)
- Difficulties with sleep or increase in sleep pattern
- Slow/poor wound healing, dry skin, hair that is dry and/or falling out, yellow/orange skin, new growth of fine body hair (lanugo), brittle nails, cuts/calluses across tops of finger joints (from self-induced vomiting)

- GI: delayed gastric emptying, slow intestinal transit time, nausea, bloating, postprandial fullness, GERD, constipation, esophageal mucosal damage, Mallory-Weiss tears, superior mesenteric artery (SMA) syndrome, hepatic transaminase concentrations and coagulation times can be elevated
- Weight loss with or without the fear of weight gain or body image concerns
- Dental problems (erosion of enamel, cavities, tooth sensitivity, swelling around salivary glands, discoloration of teeth)
- Swelling (edema)
- Frequent sickness (impaired immune system)
- Re-chewing, re-swallowing or spitting out food
- In the presence of diabetes: neglect and/or secrecy of diabetes cares, not taking medication as prescribed, infrequently filled prescriptions, missing diabetes related appointments, fear of insulin causing weight gain, restricting certain foods, A1c of 9.0 or higher on continuous basis, fear of low or high blood sugars, inconsistent meter readings, restriction of certain foods or food groups to lower insulin usage, deteriorating or blurry vision, fatigue/lethargy, frequent bladder and/or yeast infections, persistent thirst and frequent urination, nausea and/or vomiting, unexplained weight loss, low sodium and/or potassium, DKA or near DKA episodes, in addition to any of the other symptoms described above
- Renal and electrolyte effects: dehydration, electrolyte abnormalities, edema.
- Endocrine: euthyroid sick syndrome, hypercortisolemia, amenorrhea, low testosterone, smaller testicular volumes, growth delays/cessation, low bone density
- Abnormal laboratory and electrolyte possible findings:
    - CBC, CMP, Amylase, TSH, urinalysis, electrolytes.
    - **Labs associated with concern for refeeding syndrome:**
        - Low Potassium - Hypokalemia (< 3.0 mEq/L)
        - Low Phosphorus – Hypophosphatemia (< 2.5 mg/dL)
        - Low Magnesium – Hypomagnesaemia (less than 1.46 mg/dL)
    - **Labs Associated with Concern for Purging**

Method of Purging	Serum Levels					Urine Levels		
	Sodium	***Potassium***	***Chloride***	***Bicarbonate***	***pH***	***Sodium***	***Potassium***	***Chloride***
Vomiting	Increased, decreased or normal	Decreased	Decreased	Increased	Increased	Decreased	Decreased	Decreased
Laxatives	Increased or normal	Decreased	Increased or Decreased	Decreased or Increased	Decreased or Increased	Decreased	Decreased	Normal or decreased
Diuretics	Decreased or Normal	Decreased	Decreased	Increased	Increased	Increased	Increased	Increased

Mehler PS. Clinical practice. Bulimia nervosa. N Engl J Med. 2003 Aug 28;349(9):875-81. doi: 10.1056/NEJMcp022813. PMID: 12944574.

LEVELS OF CARE (LOC)



Treatment options in or near Wisconsin (updated: 1/30/24)	Locations	Ages	Pay Acceptance
OUTPATIENT			
Connected for Kids – Bellin Adolescent Medicine https://www.bellin.org/services_programs/child-adolescent-health/adolescent-care	De Pere (2024)-Green Bay (2025)	Ages 10+ (through college)	Accepts most insurances including Medicaid
Equip https://equip.health	Virtual FBT program	Ages 6+, including adults	Commercial insurance or self-pay only
Thedacare – physician referral needed from any clinic/hsp for eating disorder dietitian services	Appleton	Children, adolescents, adults	Commercial insurance, RD services not covered for patients with Medicaid (financial assistance may be available)
Local (individual) providers to form treatment team: PCP, Therapist, Registered Dietitian	In person and virtual	Varies	Varies
IOP (INTENSIVE OUTPATIENT PROGRAM)			
Monte Nido Chicago Eating Disorder Day Treatment: Monte Nido Chicago Day Treatment web page	Lombard, IL	Ages 11+	Newer program so still working on insurance contracting. But likely will be in network with BCBS and Aetna first
Rogers Behavioral Health - Child/Adolescent https://rogersbh.org/what-we-treat/eating-disorders-treatment)	Oconomowoc, WI	(internal step-down only), Ages 6+	Call: 800-767-4411
Rogers Behavioral Health - Adult	Oconomowoc, WI	Ages 18+	Call: 800-767-4411

Eating Recovery Center (ERC) – 3 days per week for 3 hours a day. Patients also will see their outpatient providers while in IOP so that they have individual support while being in IOP group support. https://www.eatingrecoverycenter.com/	Northbrook, IL	Ages 10+	Commercial insurance, not WI state insurance.
PHP (PARTIAL HOSPITAL PROGRAM)			
Monte Nido Chicago Eating Disorder Day Treatment: Monte Nido Chicago Day Treatment web page	Lombard, IL	Ages 11+	Newer program so still working on insurance contracting. But likely will be in network with BCBS and Aetna first
Rogers Behavioral Health – Child/Adolescent	Oconomowoc, WI	Ages 6+	Call: 800-767-4411
Rogers Behavioral Health – Adult	Oconomowoc, Appleton, Madison, WI	Ages 18+	Call: 800-767-4411
Eating Recovery Center (ERC) – 7 days per week. Offer housing at some locations but also have contract with hotels and Ronald McDonald.	Northbrook, IL	Ages 10+	Commercial insurance, not WI state insurance.
RESIDENTIAL			
Rogers Behavioral Health - Adolescent	Oconomowoc	Ages 12-17	Call: 800-767-4411
Rogers Behavioral Health - Adult	Oconomowoc	Ages 18+	Call: 800-767-4411
Eating Recovery Center (ERC)	Northbrook, IL	Ages 10+	Commercial insurance, not WI MA
Clementine Clementine Naperville Virtual Tour https://clementineprograms.com/program-locations/clementine-naperville/	Naperville, IL	Ages 11-17, female identifying adolescents	BCBS, AETNA in network (can do look into SCA's and out of network)
INPATIENT			
Children's Wisconsin – Adolescent Medicine (acute medical stabilization)	Milwaukee, WI	Ages 9+	Accepts most insurances including Medicaid
Eating Recovery Center (ERC) – ACUTE (acute medical stabilization)	Denver, CO	Ages 15+	Commercial insurance, not WI MA
Rogers Behavioral Health	Oconomowoc	Ages 8+	Call: 800-767-4411

WEIGHTS

Patient's weight

Patients with eating disorders are often highly fixated on their weight and body image. Desired weight loss is a common driver behind patients' decision to restrict food intake. As a result, it may be in a patient's best interest to:

- Refrain from discussing weight loss or gain.
- Encourage removal of scales at home (or at least removal of patient access to scales at home).
- At medical visits obtain "closed" weights (weight number is kept "closed" or unknown to patient)
- Omit weights on any documents provided to patients during visits.
- Focus on other health markers when making nutrition changes. For example, increased energy, improved mood, stronger hair or nails, decreased muscle fatigue during sports, etc.
- Please note:
    - Exposure and Response Prevention (ERP) is a treatment modality where use of scale/weight exposure may therapeutically be recommended.
    - Family-Based Treatment (FBT) traditionally uses open weights in therapeutically recommended ways.

"Closed" weight at medical office

IMPORTANT: keep the weight/number "closed" (unknown to patient).

1. Encourage the use of bathroom prior to weight check.
2. Take off shoes and any heavy clothing patient is wearing, this includes jackets, sweatshirts/sweaters, and any items in pockets (cellphones). It's okay to weigh patient wearing a light layer of clothing. If treatment team or caregiver(s) suspect that patient is hiding weighted items in pockets, bras, and underwear then collecting an examination gown weight would be encouraged (pending clinic protocols).
3. Keep your patient from touching nearby furniture or walls.
4. Place a light covering over the "number" screen (a post-it note typically works well), so that only clinician can see the number.
5. Have patient get on the scale backwards.
6. Do's:
    - Omit weights on any documents provided to patient during visit.
    - Refrain from discussing weight at all with patient (leave this up to treatment team to deem what is best for each individual patient).
    - Provide caregivers with weight information separately from the patient.

Children's Wisconsin: *Closed weights within clinic*	
✓ Patient takes off everything except underpants	✓ Weighed with back to scale
✓ Change into 2 gowns	✓ Try to use the same scale for every visit

Telehealth

In preparation for a telehealth visit, an updated weight check should be completed ideally the day of, or up to 2 days prior to the telehealth visit. This updated weight could be obtained through a "weight check" at the primary care office or at home, if a caregiver has access to an accurate home scale (see instructions below). In either situation, it is recommended that the weight/number is "closed".

"Closed" weight at home

If family has an accurate home scale, a closed weight check can be completed at home by following these steps. IMPORTANT: keep the weight/number "closed" (unknown to patient).

1. Encourage the use of bathroom prior to weight check.
2. Take off shoes and any heavy clothing your child is wearing. This includes jackets, sweatshirts or sweaters. It's OK to weigh your child wearing a light layer of clothing.
3. Keep your child from touching nearby furniture or walls.
4. Use the scale on a solid ground (tile/vinyl/laminate/cement flooring; not carpeting).
5. Place a light covering over the "number" screen (a post-it note typically works well), so that only parent/guardian/caregiver can see the number.
6. Have your child get on the scale backwards.
7. Return the scale to a location where the child does not have access to the scale to weigh themselves.
8. Communicate updated weight privately with healthcare team. Caution should be exercised if the child has access to the electronic medical records for this data to be seen in a chart message.
9. Refrain from disclosing weight or weight trends at all with the child; encourage them to speak directly to treatment team with questions and/or concerns.

ORTHOSTATIC VITAL CHECKS

1. Heart rate (pulse) and blood pressure obtained **after 5 minutes** of supine rest
2. And repeated **after 2 minutes** of standing
3. Orthostatic changes:

   Blood pressure: sustained **DROP** of blood pressure
   - Systolic BP >20 mm Hg
   - Diastolic BP >10 mm Hg

   Heart rate (pulse): sustained **INCREASE** of pulse
   - >40 bpm in teens aged <19 YO

PHYSICAL ACTIVITY

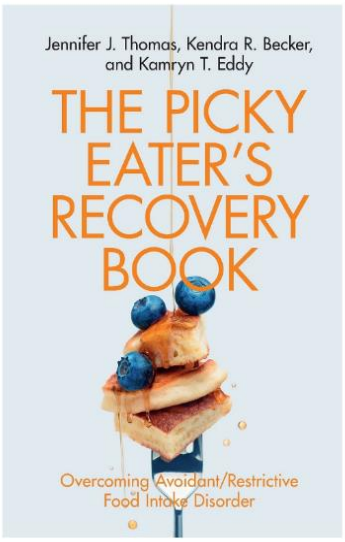
The Medical Provider, Mental Health Provider, and RD will ideally work collaboratively to determine if the patient is safe to engage in physical activity (medically, mentally, and emotionally). It is important to understand the role physical activity plays in an individual's life and eating disorder. Often, physical activity needs to be restricted initially and then gradually reincorporated with patient safety (medically, mentally and emotionally) at the forefront of any decisions made by the treatment team. If physical activity was used by the eating disorder, a therapist can be very helpful in this process of reintroduction.

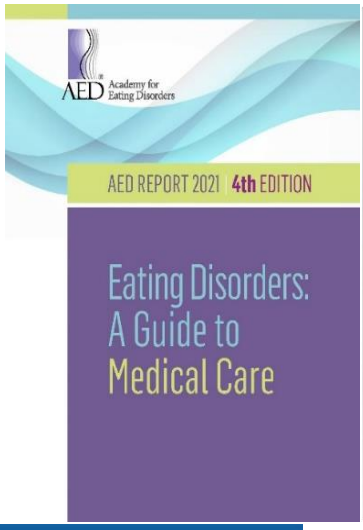
RESOURCES

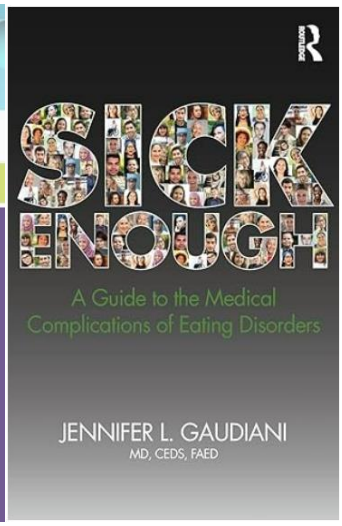
Caregiver website resources

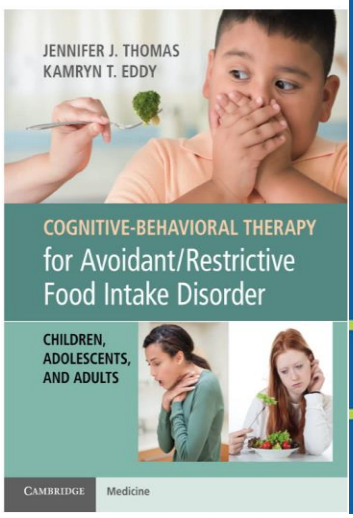
- http://www.parents-to-parents.org
- http://www.feast-ed.org/
- https://www.emilyprogram.com/for-families/resources-for-families/
- https://www.eatingrecoverycenter.com/resources/families
- https://www.nationaleatingdisorders.org/parent-toolkit

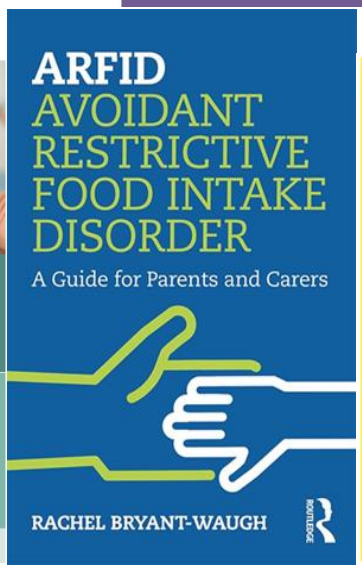
Book resources

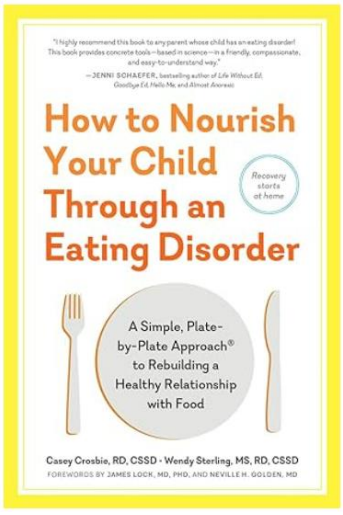


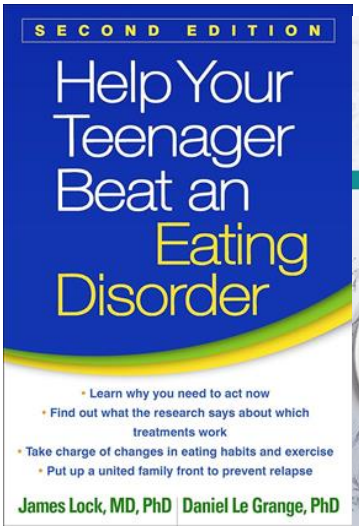


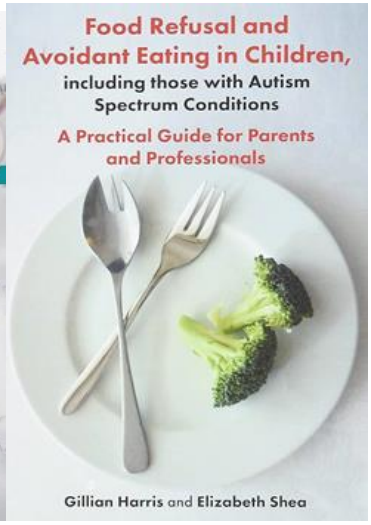


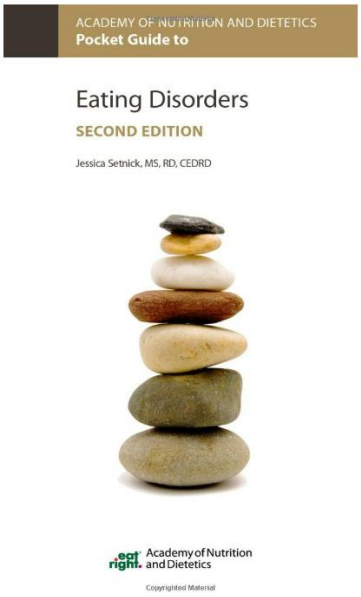


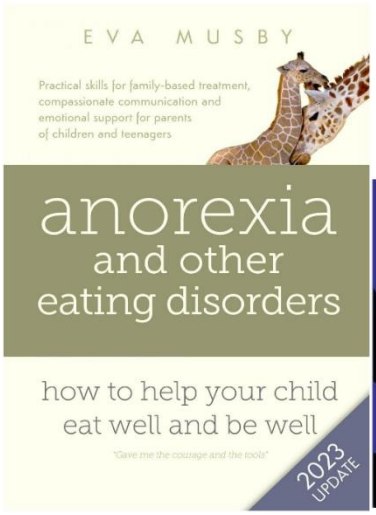


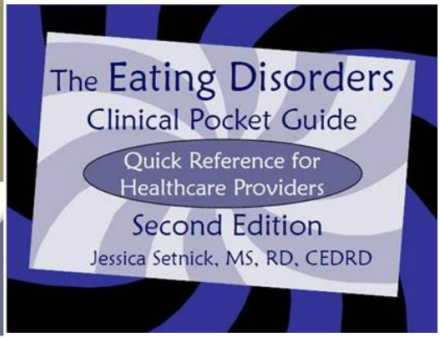












Resources for providers

- American Psychiatric Association (APA) Eating Disorder Practice Guidelines. Pocket book: https://eguideline.guidelinecentral.com/i/1492606-eating-disorders/0?

Children's Wisconsin: (inpatient) hospital admission criteria for medical stabilization

if one or more criteria present

Malnutrition

- Weight </=75% of ideal body weight (IBW) (calculation following)
- Patient eating <500 cal/day for last 3 days
- Rapid weight loss of >5% of body weight within 10 days before admission
- Acute food refusal

Cardiac Abnormalities

- Heart rate <45/min
- Cardiac arrhythmias, including prolonged QTc (If prolonged QTc exists, the patient will be admitted to the ICU for cardiac monitoring)
- Hypotension for age and sex or blood pressure <80/50mm hg
- Orthostatic changes in pulse (sustained increased >40 bpm in teens aged <19 years or sustained drop of blood pressure >20 mmHg systolic or >10 mmHg diastolic)

Electrolyte Abnormalities

- Hypokalemia (<3.0 mEq/L) (If IV K+ is required, the patient will be admitted to the ICU)
- Hypophosphatemia (<2.5 mg/dL)
- Hypochloremia (<88 mEq/L)
- Metabolic Acidosis/ Ketosis

Hypothermia (temp. <96 F)

Acute medical complications of malnutrition (e.g., syncope, seizures, cardiac failure, pancreatitis, etc.)

Acute psychiatric emergencies (e.g., suicidal ideation, acute psychosis) leading to medical instability

Co-morbid diagnosis (e.g., severe depression, obsessive-compulsive disorder, severe family dysfunction) leading to medical instability

Failure of Outpatient Treatment leading to medical instability as noted above

Arrested growth and development*

Uncontrolled binge eating or purging

*Consider the following question: Are you expecting this aged child to lose weight or fall off the height curve? Example: 9-12 year old children may not fit the admission criteria but still may need to be admitted.

Children's Wisconsin: hospital admission

✓ **If the patient has been seen in the last 24 hours AND**

✓ **Meets the criteria for admission *(prior section)***

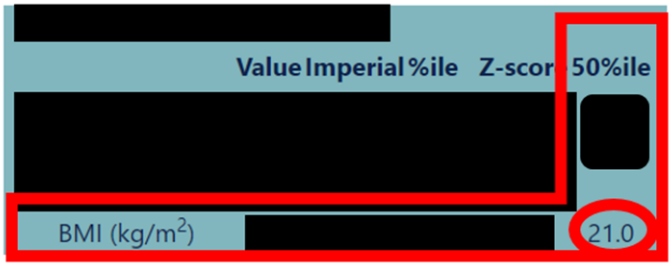
Referral for hospitalization goes through the CW referral line (for direct admits seen within the last 24 hours) or through Children's ED (if not seen within the last 24 hours)

Admission work-up (labs and tests)

1. CBC
2. CMP
3. Mg
4. Phosphate
5. TSH
6. Amylase
7. ESR
8. Pre-albumin
9. UA
10. EKG
11. Patient without prior eating disorder diagnosis: consider differential for presenting symptoms

Children's Wisconsin: calculation for "%IBW"

1. Input patient information into CDC Growth Calculator for 2 to 20 years: https://peditools.org/growthpedi/ and click "submit"
2. Locate BMI at the 50$^{\%ile}$ for age.



3. 50th%ile BMI x height (M^2) = **IBW(kg)**
4. Current weight (kg) / IBW (kg) x 100 = **%IBW**

Mental Health Providers

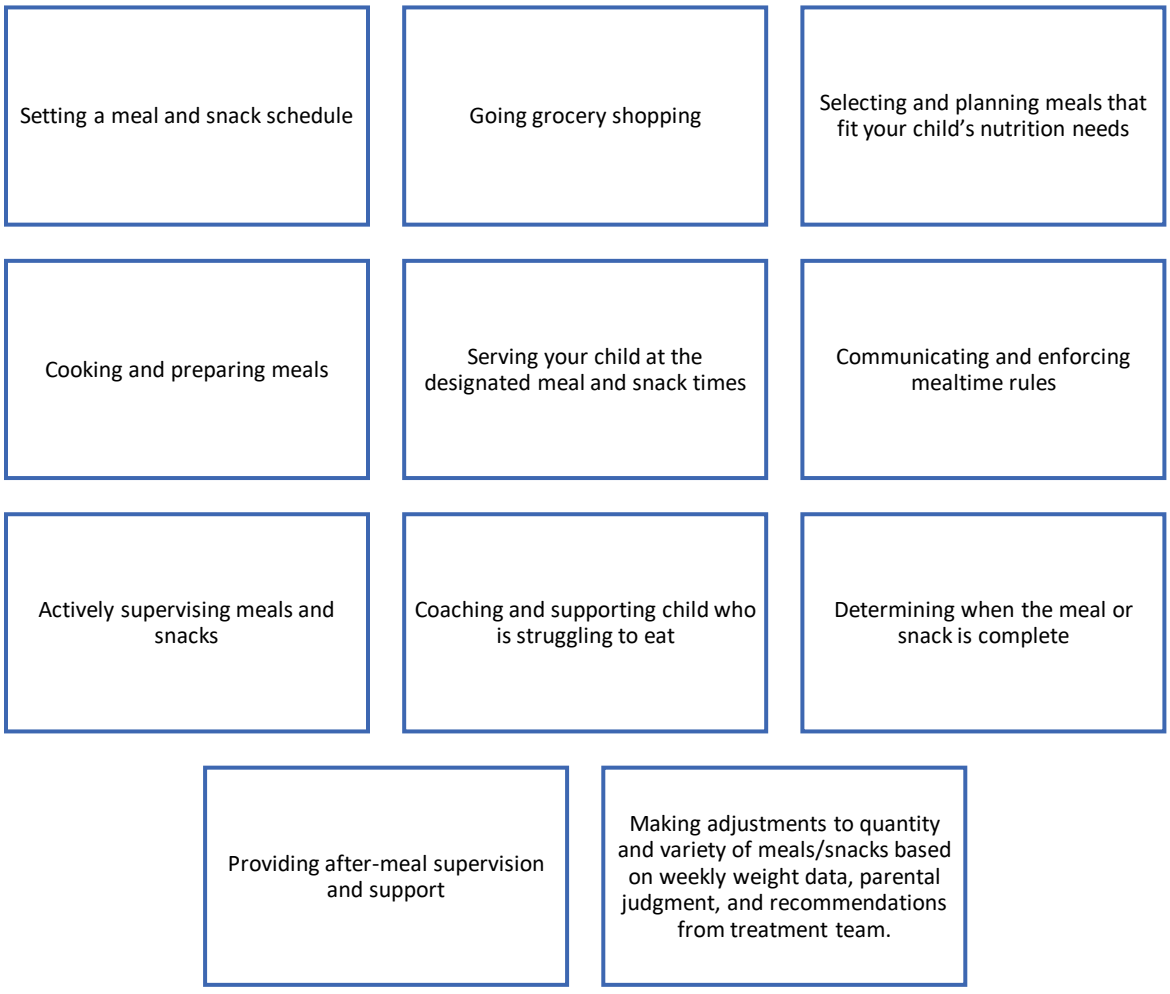
CREATE A SUPPORTIVE ENVIRONMENT

- Be empathetic
- Be nonjudgmental and non-blaming of all family members
- Use person-first language and non-stigmatizing words to describe symptoms or concerns
- Use weight-neutral language

WORKING WITH CAREGIVER(S)

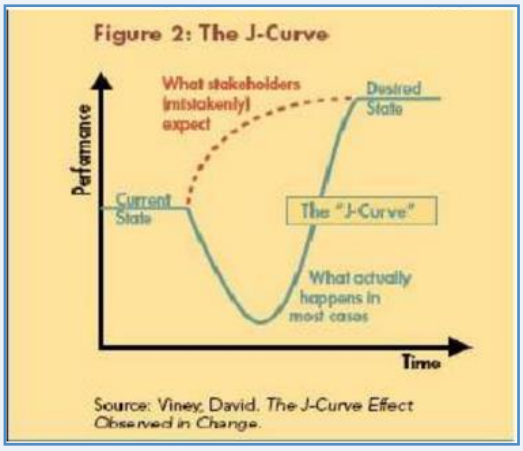
Caregiver(s) Role

- Caregiver(s) are the enforcers of the recovery rules and structure they create.
- Here are some of the responsibilities that feeding a child or teenager with anorexia will entail:



Preparing caregiver(s) for the journey ahead

A long steady climb



Sometimes things get worse before they get better

MEAL SUPPORT

Caregiver(s) can support their child at home by:

- Being completely in charge of meal and snack preparation, portioning, and serving
- Keeping the child out of the kitchen during meal preparation
- Providing one to one supervision for all meals and snacks
- Keeping firm expectations that the child must complete 100% of nutrition

During the meal or snack:

- Use verbal prompting to direct patient to eat if necessary
- Say encouraging statements like, “I know you can do this”
- Avoid negotiating or debating with the eating disorder about the food
- Monitor for hiding or throwing away food
- Use consequences if a child refuses nutrition, such as staying at the table until the meal is completed or removing screen time until the next meal or snack

Meal Coaching Prompts for Parents

A common anorexic behavior is food refusal which can manifest as rejecting and complaining about food.
Parents employ various mealtime strategies in order to have success with their child or teen completing the meal.

Direct Eating Prompts:	**Vocalizations aimed at directly prompting or pressuring the adolescent to eat**	"Take the first bite." "Start with the fruit." "Stop cutting it up." "You need to eat four bites before playing that table game." "Pick up the fork." "You have 30 minutes to complete this meal." "Scrape your plate." "Take another bite."
Physical Prompts:	**Physical movement to prompt or encourage eating or drinking**	Pushing chair in. Parents leaning in towards child and sitting on both sides. Pushing plate towards child Scraping plate for child Unscrewing cap of boost and pouring into cup for patient.
Non-direct eating prompts:	**Vocalizations which are encouraging or suggestive regarding eating**	"What's the easiest to start with?" "I'd like you to eat more" "Why aren't you eating?" "Let's get started." "Can you get started for me?" "Keep going!"
Positive Incentives:	**Vocalizations describing positive activities which can be achieved through conducting a behavior or achieving a goal.**	Offering short term rewards: "When you complete this, we will go for a walk." "Later today, we will go to the mall." Offering long term rewards: "When you are recovered, you will have less treatment hours." "When you are healthier, we will go on a family vacation."

Adapted from White, H. J., Haycraft, E., Madden, S., Rhodes, P., Miskovic-Wheatley, J., Wallis, A., . . . Meyer, C. (2014). How do parents of adolescent patients with anorexia nervosa interact with their child at mealtimes? A study of parental strategies used in the family meal session of family-based treatment. *Int. J. Eat. Disord. International Journal of Eating Disorders, 48*(1), 72-80. doi:10.1002/eat.22328

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Negative Incentives:	**Vocalizations describing the removal of an activity or the negative consequence related to engaging in the negative or unwanted behavior or achieving a goal**	"If this meal is not completed, we won't be able to go for our nightly walk." "You won't be able to see your friends if this meal is not completed." "You will lose your phone privileges if this meals goes significantly into overtime."

Summary:

Direct food related prompts are more successful at promoting food intake than providing information about the food or offering food-related choices to the adolescent.

Adolescents respond by eating more to direct-eating prompts, physical prompts, and non-direct eating prompts.

Often times, parents try to explain why the meal is important, the nutritional component, and health threats. However, research suggests that parents have less success with this strategy and have better success with direct-eating prompts and physical prompts.

It's important to note that while your Child may respond by eating, being effective against the eating disorder can and often will increase negativity at mealtime and a negative emotional tone at meal times. This negativity is accounted for by the eating disorder and not the parents!

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TYPES OF EVIDENCE-BASED TREATMENT

- Family-Based Treatment (FBT; outpatient approach) – First-line treatment recommended by American Psychological Association (APA) and Society for Adolescent Health and Medicine (SAHM)
- Enhanced Cognitive Behavioral Therapy (CBT-E; outpatient approach)
- Cognitive Behavior Therapy for ARFID (CBT-AR; outpatient approach)
- Dialectical Behavioral Therapy (DBT; often found in higher levels of care)
- Radically Open Dialectical Behavioral Therapy (RO-DBT)
- Exposure and Response Prevention (ERP; often found in higher levels of care)
- Cognitive Behavioral Therapy (CBT; often found in higher levels of care and in individual outpatient therapy)

FINDING A THERAPIST

- It is important that a patient sees a therapist who specializes in eating disorders
- Caregiver(s) can seek a therapist by:
    - Calling their insurance directly or searching on the insurance portal (specific age range and presenting concern)
    - Go to psychologytoday.com and search for providers using the location, insurance, age, and presenting concern filters. Then verify that selected provider is in-network with insurance
    - Other websites to seek eating disorder therapists: eatingdisorderhope.com, https://map.nationaleatingdisorders.org/, edreferral.com
- Questions to ask a potential therapist:
    - What treatment approach do you use?
    - What age range do you typically work with?
    - How do you include caregiver(s) in treatment?
    - How do you collaborate with medical and nutrition providers?
- It is recommended that caregiver(s) be involved in treatment as much as possible so they can learn techniques for supporting their child's recovery at home

CONSIDERATIONS FOR LEVEL OF CARE RECOMMENDATIONS

- If you are referring a patient to a higher level of care (HLOC), the HLOC facility will determine which level of care (LOC) they deem most appropriate for each patient based on information that is gathered during a phone screen (typically with patient and caregiver).
- A phone screen for HLOC does not commit a patient to HLOC.
- A HLOC phone screen recommendation can be very helpful for patient/family and treatment team to get another opinion on the recommended LOC so an informed decision can be made.

Below are some important considerations that higher level of care (HLOC) facilities may take into account when determining appropriate LOC for a patient with an eating disorder.

Patient's age, developmental level, and other factors

How old is patient? A younger child may be more appropriate for a level of care that keeps them at home, such as outpatient or PHP. Younger children or teens may struggle more with out of home placement, may be more at risk for contagion effects in inpatient setting. Caregiver(s) may have more ability to exert authoritative control over a younger child in FBT.

How would they cope in an out-of-home placement with other teens of various ages? Consider cost/benefit of intensive treatment versus missing out on school and other normal life activities and being away from home and family. Consider risk for contagion effects especially for naïve, younger, or newer diagnosis patients.

Do they demonstrate cognitive ability to participate meaningfully in CBT? A younger child (e.g., ages 8-11) may not be able to obtain benefit from CBT. Co-occurring autism, other neurodivergence, or cognitive rigidities may also be a barrier to gaining benefit from CBT.

If considering outpatient care, does patient's PCP feel comfortable with continuing to follow? Sometimes a PCP may not be comfortable closely following the patient. Often, they will feel comfortable as long as a therapist and dietitian is in place.

Caregivers

Are the caregiver(s) well-resourced, supportive, and involved? FBT requires involved caregiver(s) who are willing to take on extra effort and dedicate time to their child's recovery. Individual adolescent-focused therapy would place less burden on caregiver(s), but is not as empirically supported for patients with anorexia; may be more appropriate for patients with bulimia nervosa or binge eating disorder. Consider costs to the family for higher levels of care, as well. Outpatient may be more cost-effective.

Do caregiver(s) demonstrate high expressed emotion, discord, conflict, or parental serious mental illness? Proceed with caution in recommending FBT to a family with the above concerns. Patient may benefit from PHP, residential, or inpatient over FBT if there are ongoing psychosocial concerns such as those listed above.

What are caregiver(s)' attitudes towards healthy eating? Caregiver(s) need to buy into the idea that food is medicine, that their child requires a higher calorie daily intake for the foreseeable future, and all foods fit and will be encouraged. Sometimes caregiver(s) with high internalized diet culture or their own disordered eating may not be helpful in the context of FBT (but some can learn to adjust their language and habits).

Do caregiver(s) have flexibility in their schedules to provide supervision for all meals and snacks? Caregiver(s) may have competing responsibilities that make it difficult to supervise all meals and snacks, e.g., work, other children, single-parent household.

What insurance does family have? It may be harder to find an appropriate community therapist for patients with Medicaid. Families with HMO may face high copays or other out of pocket expenses for treatment.

Severity of illness

How long has patient been ill with the eating disorder? Treatment within year of onset is associated with better prognosis. Treatment after three years duration of illness is associated with worsened outcomes. Newer diagnosis could be factor supporting outpatient level of care.

Does patient want to recover? Verbalized desire to recover and get rid of the eating disorder can be a factor supporting outpatient level of care. A strong "no" in desire to recover would support higher level of care.

Is patient very entrenched in their eating disorder such that they have difficulty differentiating their identity from that of the eating disorder? Entrenchment with the eating disorder might support higher level of care, likely inpatient, depending on other factors.

Are there significant and persistent eating disorder behaviors such as compulsive exercising, laxative use, or frequent intentional vomiting? Such behaviors might necessitate higher level of care particularly if they are hard to manage in hospital setting or would be difficult for caregiver(s) to manage at home.

How underweight is patient? Eating disorder programs often have cut-offs for minimum percent of ideal body weight to be eligible for each level of care. The lower the weight, the more likely a higher level of care is needed in some cases (again, in consideration of other factors). For FBT, patient must be at 75% of ideal or above. Often PHP criteria would 80-85% or above.

Does patient have any psychiatric comorbidities? A patient with OCD or chronic SI may benefit from higher level of care.

Patient's eating

Is patient taking all nutrition orally? To what extent have they relied on NGT in the hospital? Taking all nutrition orally is needed to participate in outpatient treatment. NGT reliance suggests need for inpatient care.

Is solid food intake averaging at 75% or more? If patient is not completing most of their solid food by mouth, they likely need higher level of care.

Are there eating disorder behaviors that are persisting, such as slow pace of eating, taking small bites, hiding food, spitting out food, purging? Consider whether caregiver(s) are able to manage these behaviors, if behaviors increase the risk for becoming medically unstable again after discharge, and if behaviors might increase risk for parent burn-out.

Is there significant anxiety or emotion dysregulation during meals? Similar to above, consider whether caregiver(s) are able to tolerate patient's discomfort and hold firm to the expectation to finish all meals and snacks. High anxiety or emotion dysregulation may suggest PHP, residential, or inpatient.

How much meal coaching is required for patient to meet nutritional needs by mouth? Similar to above, consider sustainability in home environment for caregiver(s) to provide meal support.