The NICE guideline for the recognition and treatment of eating disorders

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Abstract

The National Institute for Health and Care Excellence (NICE) guidelines are evidence-based recommendations intended to inform clinical decisions on the prevention and management of specific health conditions in the national health services of England and Wales. Recommendations made in the guidelines are based on evidence from systematic reviews of the published literature and expert opinion and are developed by the National Guideline Alliance. The NICE guideline for the recognition and treatment of eating disorders (NG69) was published in 2017, replacing the previous 2004 guideline (CG9) and reflects a substantial increase in the evidence base in the intervening period. The guideline covers assessment, diagnosis, treatment, monitoring and inpatient care for children, young people and adults with eating disorders, specifically anorexia nervosa, binge eating disorder, bulimia nervosa and other specified feeding and eating disorder. Avoidant/restrictive food intake disorder, pica and rumination disorder are not covered. The guideline emphasises the importance of early intervention and treatment by specialist, community-based eating disorder services and the involvement of family and carers in supporting recovery. Psychological treatments, which might be eating disorder–focused cognitive behavioural therapy, eating disorder–focused family therapy or guided self-help, depending on the specific diagnosis, are recommended as the primary intervention for all eating disorders covered by the guideline. Medication is not recommended as the sole treatment for eating disorders but can be used as an adjunct. The guideline suggests collaboration with other specialist healthcare services to manage physical and mental health comorbidities, for example diabetes, and to manage the treatment of eating disorders in individuals who may be at particular risk of adverse outcomes, for example pregnant women, children and young people. Inpatient or day-patient care is recommended for those with severely compromised physical health. The guideline also provides guidance on the delivery of compulsory treatment under the Mental Health Act for individuals whose physical health is at serious risk.

1. Introduction

The National Institute for Health and Care Excellence (NICE) guideline for the recognition and treatment of eating disorders (NG69) (1) was published in May 2017 and replaces the previous clinical guideline (CG9) published in 2004. NG69 outlines recommendations for the assessment, treatment, monitoring and inpatient care of children, young people and adults with eating disorders and is intended to provide guidance for healthcare professionals, healthcare commissioners and providers, and other professionals involved in the provision of eating disorder services, as well as individuals suspected of having, or diagnosed with, an eating disorder, and their families and carers. The limited number of recommendations with evidence graded either "A" or "B" (see Table 1) in the previous (2004) guideline reflected the general lack of high-quality data at the time of its development, in particular for the treatment of anorexia nervosa and atypical eating disorders. The new guideline incorporates more recently published evidence both for treatment outcomes and problems related to the delivery of eating disorder therapies. Studies of treatments for bulimia nervosa and binge eating disorder, comparative studies of psychological and biological treatments for anorexia nervosa, and studies on the efficacy of treatments for atypical eating disorders (other specified feeding and eating disorders, OSFED) were considered for the updated guidance. The guideline does not include recommendations for the treatment of avoidant/restrictive food intake disorder due to the low level of available evidence, or for obesity (in the absence of an eating disorder), which is the focus of a separate clinical guideline (CG189).

2. Methodology

NICE guidelines are developed by the NICE guideline committee with reference to the standard methodology outlined in the NICE Guideline Manual. Recommendations are based on a systematic review of the available evidence with consideration of the clinical and cost effectiveness of the included interventions and services. Where evidence is lacking or inconclusive, recommendations are based on the consensus view of the guideline committee.

3. Recommendations

3.1 General principles of care

In addition to a general commitment to equal access to treatment, the guideline emphasises awareness among cli-

Grade		Level of evidence	
A	At least one meta-analysis, systematic review or randomised controlled trial (RCT) classified as 1++ and directly applicable to the target population of the guidelines; or a systematic review or body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results; or evidence drawn from a NICE technology appraisal.	1++	High-quality meta-analyses, systematic reviews of RCTs or RCTs with very low risk of bias.
		1+	Well-conducted meta-analyses, systematic reviews of RCTs or RCTs with a low risk of bias.
B	A body of evidence including studies rated as 2++, directly applicable to the target population of the guidelines and demonstrating overall consistency of results; or evidence extrapolated from studies rated as 1++ or 1+.	2++	High-quality systematic reviews of case–control or cohort studies. High-quality case–control or cohort studies with a very low risk of bias and a high probability that the relationship is causal.
C	A body of evidence including studies rates as 2+, directly applicable to the target population of the guidelines, and demonstrating overall consistency of results; or evidence extrapolated from studies rated as 2++.	2+	Well-conducted case–control cohort studies with a low risk of bias and a moderate probability that the relationship is causal.
D	Evidence level 3 or 4; or evidence extrapolated from studies rated as 2+; or formal consensus.	3	Non-analytical studies such as case reports and case series.
		4	Expert opinion or formal consensus.

Table 1. Recommendation grades and corresponding levels of evidence

nicians of the distress individuals with eating disorders may feel in discussing their condition, their possible feelings of stigma and shame and the need for information and interventions specific to their age and level of development.

Eating disorders should be assessed in the context of each individual's home, educational, work and wider social environment, including the influence of the internet and social media.

Family members, carers, teachers and peers are encouraged to play a role in supporting individuals during treatment but may also require support for their own health. Confidentiality should be maintained, within the limits imposed by the requirements of working within a multidisciplinary team. The guidance suggests that consent for assessments and treatments for children under the age of 16 years should be sought on the basis of Gillick competence, that is, a clinical determination that the child is competent to give consent to medical treatment in the same way as an autonomous adult (2, 3). The adequacy and appropriateness of this approach in a broader medical context has been questioned, however (4-6), and the full NICE guideline emphasises that there should be no assumption of capacity for individuals under the age of 16 years. The Care Quality Commission guidance on the treatment of anorexia nervosa under the Mental Health Act 1983 (7), cited in the full guideline, also imposes caveats on the assumption of capacity in individuals over the age of 16 years up to the age of 18 years. Additionally, safeguards established in law by the Protection of Children Act 1999 (8) apply to all those under the age of 18 years.

3.2 Identification and assessment

The general guidance regarding assessment and treatment states that these should be carried out at the earliest opportunity, and priority given to those at risk of severe emaciation. While "severe emaciation" is not defined by NICE, emaciation has been defined elsewhere as being below 10% of the standard weight of the normal population, and significant body weight loss as weight loss of more than 20% (9). Results from assessments with screening tools such as the SCOFF (Sick Control One Fat Food) questionnaire (10) are not recommended as the sole means of determining an eating disorder diagnosis, and clinicians should also consider key factors including unusually low or high body mass index (BMI) or body weight for age, rapid weight loss, dieting or restrictive eating practices and changes in eating behaviour reported by family or carers (see Box 1). In children and adolescents, attention should be paid to signs of faltering growth, delayed puberty or stunted height.

Assessment of individuals with a suspected eating disorder should include an examination of physical health, including signs of malnutrition and compensatory behaviours (for example, self-induced vomiting, misuse of laxatives or diet pills, or excessive exercise), assessment of neurodevelopmental disorders and mental health problems commonly associated with eating disorders (for example autism spectrum disorder, depression, anxiety, self-harm and obsessive-compulsive disorder), and evidence of alcohol or substance misuse. Where compensatory behaviour is suspected, assessment of fluid and electrolyte balance should be conducted. The need for electrocardiogram (ECG) monitoring should be assessed in those who might be at risk of cardiac irregularities, for example due to rapid weight loss, excessive exercise or severe purging behaviours. The need for emergency care in those with compromised physical health or who may be at risk of suicide should also be considered.

Decisions on whether to offer treatment should not be based on a single measure, such as BMI or duration of illness.

Based on the initial assessment, individuals with a suspected eating disorder should be referred immediately to a community-based, age-appropriate eating disorder service for further assessment and treatment.

Box 1. Factors to consider when assessing for an eating disorder or when deciding to refer people for assessment

1. An unusually low or high body mass index (BMI) or body weight for age.
2. Rapid weight loss.
3. Dieting or restrictive eating practices (such as dieting when they are underweight) that are worrying the individual, their family members or carers, or professionals.
4. Family members or carers report a change in eating behaviour.
5. Social withdrawal, particularly from situations that involve food.
6. Other mental health problems.
7. A disproportionate concern about their weight or shape (e.g., concerns about weight gain as a side effect of contraceptive medication).
8. Problems managing a chronic illness that affects diet, such as diabetes or coeliac disease.
9. Menstrual or other endocrine disturbances or unexplained gastrointestinal symptoms.
10. Physical signs of:
    - Malnutrition, including poor circulation, dizziness, palpitations, fainting or pallor.
    - Compensatory behaviours, including laxative or diet pill misuse, vomiting or excessive exercise.
11. Abdominal pain that is associated with vomiting or restrictions in diet that cannot be fully explained by a medical condition.
12. Unexplained electrolyte imbalance or hypoglycaemia.
13. Atypical dental wear (such as erosion).
14. Whether the individual takes part in activities associated with a high risk of eating disorders (e.g. professional sport, fashion, dance or modelling).

3.3 Recommendations for treatment

3.3.1 Common recommendations for treatment

Psychological treatments are recommended as the first-choice interventions for adults, children and young people with anorexia nervosa, binge eating disorder, bulimia nervosa or OSFED. The recommendations encompass a broad range of psychotherapeutic strategies, some of which are specific to a particular eating disorder (for example, the Maudsley Anorexia Nervosa Treatment for Adults), reflecting both the diversity and disparity of approaches to treatment, and a recognition of the importance of considering individual needs and preferences (see Tables 2–5 for a comparison of the recommendations).

Medication should not be offered as the sole treatment for an eating disorder. It was considered by the guideline committee that physical therapy, including transcranial magnetic stimulation, acupuncture, weight training, yoga and warming therapy, should not be offered as any part of treatment due to the general lack of evidence for the efficacy of these approaches, specifically with regard to remission, and the low quality of the evidence that is available.

Acute medical care should be provided for individuals in whom severe electrolyte imbalance, severe malnutrition, severe dehydration or incipient organ failure are detected.

3.3.2 Treating anorexia nervosa

All individuals with anorexia nervosa should be provided with multidisciplinary support including psychoeducation about the disorder, monitoring of weight, mental and physical health, and risk factors. Dietary counselling should also be offered, although the form that this should take is not specified in the guideline.

The guideline emphasises the goal of helping the person with anorexia nervosa to reach a healthy body weight or BMI for their age.

If treatment for anorexia nervosa is declined or ineffective, individuals without severe or complex problems should be discharged to primary care and advised that they can seek referral for treatment again at any time. A review of physical and mental health, including assessment of weight or BMI, blood pressure and ECG monitoring where necessary, should be offered at least annually to individuals with anorexia nervosa who are not receiving ongoing treatment. Children and young people who have not completed puberty should also be monitored for growth and development.

Bone density scans should be considered after 1 year of underweight in children and young people and after 2 years of underweight in adults (earlier in the event of bone pain or recurrent fractures). Treatment with transdermal 17-β-oestradiol (with cyclic progesterone) should be considered in young women (aged 13 to 17 years) with long-term low body weight and low bone mineral density with a bone age over 15 years, and treatment with physiological doses of oestrogen in those additionally exhibiting delayed puberty. However, routine treatment with oral or transdermal oestrogen to treat low bone mineral density in children and young people is not recommended. Oestradiol fuses bone growth plates so it is important to ensure that growth is complete before giving therapeutic oestradiol. It should also be considered that recent growth spurts could temporarily result in low bone mineral density of the lumbar spine. Specialist paediatric or endocrinological advice should be sought before starting any hormonal treatment

for low bone mineral density, and treatment should be coordinated with the eating disorder team. Treatment with biphosphates should be considered for women over 18 years of age. Combined oral contraceptives are not recommended for bone protection. Clinicians should refer to the NICE guideline on assessing the risk of fragility fractures in osteoporosis (CG146) for further guidance.

Amenorrhea is no longer included among the diagnostic criteria for anorexia nervosa in females. However, assessment of menstrual function, determination of amenorrhea and separation of primary and secondary amenorrhea/functional hypothalamic amenorrhea (FHA) due to disordered or restrictive eating should still be performed. Where secondary amenorrhea is present and associated with low bone mineral density for age (based on bone mineral density z-score if under 40 years), then hormone replacement therapy (HRT) is indicated. Where subclinical ovulatory disturbance, rather than "full" FHA, is detected and HRT is initiated to maintain bone health, an attempt should be made to synchronise sequential HRT with the menstrual cycle.

3.3.2.1 Adults with anorexia nervosa

For adults with anorexia nervosa, psychological treatment should be offered in the form of individual eating disorder–focused cognitive behavioural therapy (CBT-ED), the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) or specialist supportive clinical management (SSCM). If CBT-ED, MANTRA or SSCM is unacceptable, contraindicated or ineffective, the guideline recommends offering one of the other options from this group that has not already been tried or, alternatively, offering eating disorder–focused focal psychodynamic therapy (FPT). See Table 2 for a comparison of these interventions.

3.3.2.2 Children and young people with anorexia nervosa

The guideline recommends considering anorexia nervosa–focused family therapy (FT-AN) for children and young people with anorexia nervosa, either in the form of single-family therapy or combined single-family and multi-family therapy. Children and young people should be offered the option to attend some sessions separately from their family and carers. If FT-AN is unacceptable, contraindicated or ineffective, individuals should be offered individual CBT-ED or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN). See Table 3 for a comparison of these interventions.

3.3.3 Treating binge eating disorder

Psychological treatments for binge eating disorder are not aimed at weight loss. Where obesity is a concern in individuals with binge eating disorder, further reference should be made to the NICE guideline on obesity identification, assessment and management (CG189).

3.3.3.1 Adults, children and young people with binge eating disorder

The guideline suggests all individuals with binge eating disorder should be offered a binge eating disorder–focused guided self-help programme. If this is unacceptable, contraindicated or ineffective, group or individual CBT-ED should be offered. See Table 4 for a comparison of these approaches.

3.3.4 Treating bulimia nervosa

Individuals with bulimia nervosa should be advised that psychological interventions have a limited effect on body weight.

3.3.4.1 Adults with bulimia nervosa

Adults should be offered a bulimia nervosa–focused guided self-help programme incorporating cognitive behavioural self-help materials for eating disorders. Guided self-help should be supplemented by a series of brief support sessions. The guideline suggests 4 to 9 sessions of 20 minutes each over 16 weeks, initially on a weekly basis.

If guided self-help is unacceptable, contraindicated or ineffective after 4 weeks, adults with bulimia nervosa should be offered individual CBT-ED (see Table 5).

3.3.4.2 Children and young people with bulimia nervosa

Children and young people should be offered bulimia nervosa–focused family therapy (FT-BN). As part of this approach, the young person and their parents should be encouraged to develop a collaborative approach to establishing healthy eating behaviours. Support should also be considered for family members not involved in the family therapy sessions. If FT-BN is unacceptable, contraindicated or ineffective, CBT-ED should be considered (see Table 5).

3.3.5 Treating other specified feeding and eating disorders

There are no specific recommendations for the treatment of OSFED. Instead, the guideline suggests that the most appropriate treatment be selected based on consideration of the eating disorder it most closely resembles.

4. Physical and mental health comorbidities

Eating disorder specialists and other healthcare teams should collaborate to monitor the effectiveness of the treatments for the eating disorder and comorbid conditions using appropriate outcome measures and assess the potential impact of each treatment on the others.

4.1 Diabetes

The guideline specifies collaboration between eating disorder and diabetes teams to monitor and manage physical and mental health. Additional recommendations for the treatment of eating disorders in people with comorbid diabetes include close monitoring of blood glucose and blood ketones and addressing the possibility of insulin misuse. People with bulimia nervosa and diabetes should also be considered for monitoring for glucose toxicity (hyperglycaemia-induced inhibition of insulin secretion and glucose metabolism (11, 12)), insulin resistance, ketoacidosis and oedema. Clinicians are advised to refer to the NICE guideline on type I and type II diabetes in children and young people (NG18), type I diabetes in adults (NG17) and type II diabetes in adults (NG28) for further guidance.

4.2 Comorbid mental health problems

Decisions on whether to treat comorbid mental health problems in parallel with the eating disorder or separately and in sequence should be taken with consideration of the relative severity and complexity of the eating disorder and the mental health problem, the individual's level of functioning and the preferences of the individual as well as those of their family or carers, where appropriate. Clinicians are advised to refer to the NICE guidelines for the specific mental health problem for further guidance.

4.3 Medication risk management

Where medication is prescribed to treat a comorbid mental or physical health condition, consideration should be given to the possible effects of malnutrition and compensatory behaviours on effectiveness and side effects, and the possible effect of the eating disorder on medication adherence, for example, where medication might affect body weight. Pre-existing medical complications should be considered and ECG monitoring offered to individuals taking medication that might affect cardiac function.

4.4 Substance or medication misuse

Substance misuse should not preclude treatment for eating disorders unless it interferes with treatment. If substance misuse does interfere with treatment, a multidisciplinary approach involving substance misuse services is proposed.

4.5 Growth and development

The guideline suggests that concerns about delayed physical development or faltering growth in children and young people with an eating disorder should be referred to a specialist paediatrician or endocrinologist.

5. Conception and pregnancy

Treatment for eating disorders during the perinatal period should follow the standard treatment guidelines for the appropriate eating disorder. More intensive prenatal care for women with current or remitted anorexia nervosa should be considered to ensure adequate prenatal nutrition. Education and advice should be offered to all women with an eating disorder who plan to conceive, in order to increase the chances of conception and to reduce the risk of miscarriage. A dedicated professional (e.g., GP or midwife) should be responsible for supporting and monitoring women during pregnancy and the postnatal period to reduce possible risks to the health of the mother and child, with reference to the NICE guideline on antenatal and postnatal mental health (CG192). Guidance on providing advice to pregnant women about healthy eating and feeding their baby is available in the NICE public health guideline on maternal and child nutrition (PH11).

6. Inpatient and day-patient treatment

Previously, inpatient care was central to the management of eating disorders. More recently, community-based care has been preferred, and inpatient hospital admissions are generally limited to those with severe medical risk or who have failed to respond to outpatient care.

If physical health is severely compromised, individuals should be admitted to a medical inpatient or day-patient service for medical stabilisation and refeeding, if this is not possible in an outpatient setting. The decision on whether to admit to inpatient or day-patient care should not be based on absolute weight or BMI. Inpatient care is recommended in cases of rapid weight loss (e.g., more than 1 kg per week), or when medical risk parameters (e.g., blood tests, physical observations and ECG) have values or rates of change in the concern or alert ranges requiring active monitoring. Other factors that might influence the decision to admit to inpatient care include a significant decline in physical health and whether parents or carers of children and young people have the ability to support them and avoid significant harm under day-patient care. Clinicians are advised to consult the Royal College of Psychiatrists' resource on Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) or the junior MARSIPAN report. Since 2022,

these guidelines have been superseded by the Medical Emergencies in Eating Disorders (MEED) guidance (13).

A care plan should be developed in collaboration with individuals admitted to inpatient care, their families or carers, and the community-based eating disorder service. This should include the objectives and outcomes for the admission, planning for discharge and transition back to community-based care.

Inpatient care should not be used solely to provide psychological treatment for eating disorders. In individuals considered to be at acute mental health risk (e.g., significant suicide risk), psychiatric crisis care or psychiatric inpatient care should be considered. Inpatient care for children and young people should be provided in age-appropriate settings and be located near the individual's home.

Refeeding should take place under the direction of staff trained to recognise the symptoms of refeeding syndrome and how it should be managed.

Inpatient care should be reviewed within 1 month of admission. The decision to discharge an individual from inpatient care should not be made solely on the basis of an achieved healthy weight.

7. Compulsory treatment and the Mental Health Act

Where it is determined that a person's physical health is at serious risk due to an eating disorder, they do not consent to treatment and it is considered that they can only be treated safely in an inpatient setting, the guideline recommends following the legal framework for compulsory treatment set out in the Mental Health Act 1983. Where this situation applies to a child or young person, their parents or carers should be asked to provide consent on their behalf, if necessary, under the terms of a legal framework for compulsory treatment, for example, those set out in the Mental Health Act 1983/2007 (14) or the Children Act 1989 (15).

8. Comment

8.1 Quality of evidence

Despite forming the basis for the treatment recommendations made in the guideline, the quality of the evidence supporting the use of psychological interventions for eating disorders was, in most cases, considered low or very low according to GRADE (Grading of Recommendations Assessment, Development and Evaluation) criteria. Evidence was frequently downgraded due to indirectness, imprecision and risk of bias. A further limitation was the general lack of data for the efficacy of treatments in males. Evidence for pharmacological and nutritional interventions (e.g., nutritional counselling and dietary supplements) were graded low or very low, leading to the recommendation that they should not be used as sole treatments for eating disorders. Evidence for physical interventions (e.g., physiotherapy, yoga, physical exercise and acupuncture) was, in most cases, considered to be very low quality.

8.2 Recommendations for future research

The guideline makes several recommendations for further research to address limitations of the current evidence. These include:

- Comparison of the clinical and cost effectiveness of individual CBT-ED, group CBT-ED and guided self-help for adults with binge eating disorders.
- Investigation of the effectiveness of reduced duration and intensity of psychological treatments for eating disorders compared with standard treatment.
- Investigation of the clinical biochemical markers that best predict acute physical risk for people with eating disorders.
- Investigation of the impact of comorbidities on treatment outcomes for eating disorders and effective approaches to the management of comorbidities.
- Investigation of factors associated with continued benefit after successful treatment for anorexia nervosa.

9. Challenges to implementation

In their summary of current treatment provision for eating disorders in the NHS, the guideline committee highlighted a number of disparities in the care offered in both paediatric and adult services, often reflecting regional inequalities in funding and referral criteria. These inconsistencies apply to all aspects of eating disorder care provision, including recognition, assessment, treatment, including access to specialist eating disorder services, and transition between services, and are reflected in a high degree of variability in basic treatment strategies and settings. For example, the lack of specialist eating disorder services in some regions has meant that children and young people with eating disorders may be treated by generic Child and Adolescent Mental Health Services teams. The age thresholds for access to specialist services and transitioning to adult services also vary. In an attempt to standardise access to care pathways for children and young people, a commissioning guide, the Access and Waiting Times initiative, was published in 2015. However, this only applies to individuals under the age of 18. Access to specialist care for adults is highly dependent on funding allocation, with some regions offering referrals only to those who meet strict criteria, for example, based

on BMI thresholds, despite attempts to gain parity for eating disorders across the lifespan.

Primary care practitioners are often the first point of contact for individuals with eating disorders, but experience, skill and confidence in making a preliminary assessment and diagnosis are highly variable. Clinicians also have varying degrees of knowledge of and experience in delivering specific interventions.

With regard to inpatient care, there are no internationally recognised criteria for admission. In practice, the availability and form of inpatient care depend on the extent of local facilities and the acute care they are able to provide. In the UK, the MARSIPAN protocol, recently superseded by the MEED guidance, outlines the care pathway for admission to inpatient care for those at extreme medical risk and highlights the responsibilities of healthcare professionals at every level of care provision.

It remains highly desirable to avoid inpatient admissions, not least due to the potential stigma involved, in particular that associated with compulsory admissions. This may have a negative effect on both self-image and the quality of life of the individual. In the last two decades, practice in England and Wales has moved away from an emphasis on in-patient treatment and the focus is now on limiting the duration of hospitalisation and minimising compulsion, which is in line with the NHS Long Term Plan (16). Although not mentioned in the NICE guidance, this situation is exemplified by recent changes in the protocol for nasogastric tube feeding which can now be delivered, in most cases, in an intensive outpatient setting without the need for extended inpatient admission (see the article on nasogastric tube feeding under physical restraint elsewhere in this issue).

Conflicts of interest

The authors declare that they have no conflicts of interest.

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	CBT-ED	MANTRA	SSCM	FPT
Duration	Typically 40 sessions over 40 weeks. Twice-weekly sessions in the first 2 or 3 weeks.	Typically 20 sessions. Weekly sessions for the first 10 weeks and a flexible schedule for the remainder of the sessions. Up to 10 extra sessions for people with complex problems.	Typically 20 or more weekly sessions (depending on severity).	Typically up to 40 sessions over 40 weeks.
Approach	Aim to reduce the risk to physical health and any other symptoms of the eating disorder. Encourage healthy eating and reaching a healthy body weight. Create a personalised treatment plan based on processes that appear to be maintaining the eating problem. Enhance self-efficacy. Include self-monitoring of dietary intake and associated thoughts and feelings. Include homework to help the person practice in their daily life what they have learned.	1. Getting started and finding motivation for recovery 2. Working with support, including family and others 3. Improving nutritional health 4. Understanding anorexia 5. Developing treatment goals 6. Understanding and relating to emotions helpfully 7. Exploring thinking styles, and challenging styles that are rigid, perfectionist, attention to detail 8. Developing identity outside of the eating disorder 9. Relapse prevention Motivate the person and encourage them to work with the practitioner. Be flexible in how the modules of MANTRA are delivered and emphasised. Encourage the person to develop a "non-anorexic identity". Involve family members or carers to help the person: - Understand their condition and the problems it causes and the link to the wider social context. - Change their behaviour.	Assess, identify and regularly review key problems. Aim to develop a positive relationship between the person and the practitioner. Aim to help people recognise the link between their symptoms and their abnormal eating behaviour. Aim to restore weight. Include physical health monitoring. Establish a weight range goal. Encourage reaching a healthy body weight and healthy eating.	Patient-centred focal hypothesis specific to the individual that addresses: - What the symptoms mean to the person. - How the symptoms affect the person. - How the symptoms influence the person's relationships with others and with the therapist. First phase Focus on developing therapeutic alliance between therapist and person with AN. Address pro-anorexic behaviour and ego-syntonic beliefs and build self-esteem. Second phase Focus on relevant relationships with other people and how these affect eating behaviour. Final phase Focus on transferring therapy experiences to situations in everyday life and address concerns about what will happen when treatment ends.
Components	Nutrition, cognitive restructuring, mood regulation, social skills, body-image concerns, self-esteem and relapse prevention. Explain the risks of malnutrition and being underweight.	When the person is ready, cover nutrition, symptom management and behaviour change.	Provide psychoeducation and nutritional education and advice. Allow the person to decide what else should be included as part of their therapy.	

Table 2. Comparision of recommended psychological treatments for anorexia nervosa in adults (Abbreviations used in Tables 2 - 5 are expanded at the bottom of Table 5)

	FT-AN	CBT-ED	AFP-AN
Duration	Typically 18 to 20 sessions over 1 year. Review needs of the child or young person 4 weeks after starting treatment and then every 3 months to establish regularity of sessions and duration of treatment.	Typically up to 40 sessions over 40 weeks. Twice-weekly sessions in the first 2 or 3 weeks. 8 to 12 additional brief family sessions with the person and their parents or carers (as appropriate).	Typically 32 to 40 individual sessions over 12 to 18 months. More regular sessions early on to help the child or young person build a relationship with the practitioner and motivate them to change their behaviour. 8 to 12 additional family sessions with the child or young person and their parents or carers (as appropriate). Review needs of the child or young person 4 weeks after starting treatment and then every 3 months to establish regularity of sessions and duration of treatment.
Approach	Emphasise the role of the family in helping person to recover. Avoid blaming the child or young person or their family members or carers. Include psychoeducation about nutrition and the effects of malnutrition. Early in treatment, support parents or carers to take a central role in helping child or young person manage their eating. Emphasise that this is a temporary role. First phase Aim to establish a good therapeutic alliance between the child or young person, their parents or carers and other family members. Second phase Support the child or young person (with help from their parents or carers) to establish a level of independence appropriate for their level of development. Final phase Focus on plans for when treatment ends (including any concerns the child or young person and their family have) and on relapse prevention. Address how the child or young person can get support if treatment is stopped.	In family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition. In family sessions: - Identify anything in the child or young person's home life that could make it difficult for them to change their behaviour and find ways to address this. - Discuss meal plans. Aim to reduce the risk to physical health and any other symptoms of the eating disorder. Encourage reaching a healthy body weight and healthy eating. Create a personalised treatment plan based on the processes that appear to be maintaining the eating problem. Take into account the child or young person's specific development needs. Enhance self-efficacy. Include self-monitoring of dietary intake and associated thoughts and feelings. Include homework to help the child or young person practice what they have learned in their daily life. Address how the child or young person can get support if treatment is stopped.	In family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition. Focus on the child or young person's self-image, emotions and interpersonal processes and how these affect their eating disorder. Develop a formulation of the child or young person's psychological issues and how they use anorexic behaviour as a coping strategy. Address fears about weight gain and emphasise that weight gain and healthy eating is a critical part of therapy. Find alternative strategies for the person to manage stress. In later stages of treatment, explore issues of identity and build independence. Towards end of treatment, focus on transferring the therapy experience to situations in everyday life. In family sessions, help parents or carers support the child or young person to change their behaviour. Address how the child or young person can get support if treatment is stopped.
Components		Nutrition, relapse prevention, cognitive restructuring, mood regulation, social skills, body-image concerns and self-esteem. Explain the risks of malnutrition and being underweight.	

Table 3. Comparision of recommended psychological treatments for anorexia nervosa in children and young people

	BED-focused guided self-help	Group CBT-ED	Individual CBT-ED
Duration		Typically 16 weekly group sessions of 90 minutes each over 4 months.	Typically 16 to 20 sessions.
Approach	Use cognitive behavioural self-help materials for eating disorders. Focus on adherence to the self-help programme. Supplement with brief supportive sessions (e.g., 4 to 9 sessions of 20 minutes each over 16 weeks, on an initial weekly basis).	Focus on education, self-monitoring of eating behaviour and help in analysing individual problems and goals. Development of daily food intake plan and identification of binge eating cues. Body exposure training and help in identifying and correcting individual negative beliefs about their body. Help with avoiding relapse and current and future risks and triggers.	Develop a formulation of individual psychological issues to determine how dietary and emotional factors contribute to the binge eating. Advise to eat regular meals and snacks to avoid feeling hungry. Address emotional triggers for binge eating using cognitive restructuring, behavioural experiments and exposure. Include weekly monitoring of binge eating behaviours, dietary intake and weight. Weight records to be shared with individual. Address body-image issues if present. Advise against attempt at losing weight (e.g., by dieting) during treatment as this might trigger binge eating.

Table 4. Comparision of recommended psychological treatments for binge eating disorder in adults, children and young people

	Adults		Children and young people	
	BN-focused guided self-help	Individual CBT-ED	FT-BN	Individual CBT-ED
Duration		Typically up to 20 sessions over 20 weeks. Consider twice-weekly sessions in first phase.	Typically 18 to 20 sessions over 6 months.	Typically 18 sessions over 6 months. More frequent sessions early in treatment. Include up to 4 additional sessions with parents or carers.
Approach	Use cognitive behavioural self-help materials for eating disorders. Supplement with brief supportive sessions (e.g., 4 to 9 sessions of 20 minutes each over 16 weeks, on an initial weekly basis).	Initially focus on: - Engagement and education. - Establishing pattern of regular eating and providing encouragement and support. Address eating disorder psychopathology (e.g., extreme dietary restraint, body shape and weight concerns, tendency to binge eat in response to difficult thoughts and feelings). Towards end of treatment focus on maintaining positive changes and minimising risk of relapse. If appropriate, involve significant others to help with one-to-one treatment.	Establish a good therapeutic relationship with child or young person and their family members or carers. Support and encourage family members to assist in recovery. Avoid attributing blame to child or young person, their family members or carers. Use a collaborative approach between parents and child or young person to establish regular eating patterns and minimise compensatory behaviours. Include regular meetings with child or young person on their own. Include self-monitoring of bulimic behaviours and discussions with family members or carers. In later phases, support child or young person and their family members or carers to establish level of independence appropriate to their level of development. In final phase, focus on treatment plans for when treatment ends and on relapse prevention.	Initially focus on role of bulimia nervosa in child or young person's life and on building motivation to change. Provide psychoeducation about eating disorders and how symptoms are maintained. Encourage child or young person gradually to establish regular eating habits. Develop case formulation with child or young person. Teach the child or young person to monitor their thoughts, feelings and behaviours. Set goals and encourage the child or young person to address problematic thoughts, beliefs and behaviours with problem solving. Use relapse prevention strategies to prepare for and mitigate potential future setbacks. In sessions with parents and carers: - Provide education about eating disorders. - Identify family factors that stop child or young person from changing behaviour. - Discuss how family can support recovery.
Components			Include information about: - Regulating body weight. - Dieting. - Adverse effects of attempts at weight control by self-induced vomiting, laxatives or other compensatory behaviours.	

Table 5. Comparision of recommended psychological treatments for bulimia nervosa

Abbreviations: AFP-AN = adolescent-focused psychotherapy for anorexia nervosa; AN = anorexia nervosa; BED = binge eating disorder; CBT-ED = eating disorder-focused cognitive behavioural therapy; FPT = focal psychodynamic therapy; FT-AN = anorexia nervosa-focused family therapy; FT-BN = bulimia nervosa-focused family therapy; MANTRA = Maudsley Anorexia Nervosa Treatment for Adults; SSCM = specialist supportive clinical management