UCSF Benioff Children's Hospitals | Child & Adolescent Psychiatry Portal

Eating Disorders in Primary Care

Guide for Pediatric Providers

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Quick Tips

- Eating disorders occur in:
    - any body size, and may or may not be associated with weight loss
    - all racial, ethnic, and socioeconomic groups
- Eating disorders carry the second highest mortality rate of any psychiatric disorder and can impact every organ system in the body
    - Medical monitoring is essential
- Eating disorders do not tend to resolve without treatment – monitor closely and refer for specialty care when possible
- Regular nutrition (and weight restoration when needed) is essential for recovery – support patient and family to prioritize nutrition above all else, short of acute safety concerns (e.g., suicidality)

More information is contained in this guide.

Evaluation of Eating Disorders

Vitals Physical Exam	Height, Blinded Weight, Temperature Orthostatic vitals (see below) BMI, Growth chart assessment Cardiovascular, Dermatologic, Dental
History	Weight history Body image, Self-esteem Eating habits • 24-hour diet history (recent) • Calorie counting • Avoidance of specific food groups, recent shift to veganism/vegetarianism • Fluid intake Restricting, Binging or Purging behaviors Exercise patterns Substance use (Laxative/diet pills, Stimulants, Other) LMP, menstrual patterns Cardiac symptoms • Dizziness, presyncope, syncope, exercise intolerance, chest pain, etc GI symptoms • Constipation, Reduced gastric motility, Hepatitis, pancreatitis Dermatologic: Dry skin, hair loss Family Hx, Psychiatric Hx, Social Hx, Family dynamics
Differential Diagnosis	GI disorders (Celiac, IBD) Endocrine disorders (Diabetes, Hyperthyroidism) Malignancy Superior Mesenteric artery (SMA) syndrome Depression, Anxiety, OCD, Trauma
Initial Labs	• Complete Blood Count (CBC) • Comprehensive Metabolic Panel (CMP) • Liver Function Test (LFT) • Magnesium, Phosphate • Thyroid function test (T3, T4, TSH) • Erythrocyte Sedimentation Rate (ESR) • Urinalysis (UA) • EKG • If amenorrhea >6 months: urine pregnancy, LH, FSH, Prolactin, DEXA Scan

Eating Disorder Vital Sign Protocol

Urine Sample:

- Pt provides a urine sample upon arrival.
- If pt states that they have recently gone to the bathroom, emphasize that they need to try to urinate. Most pts are able to provide a sample if they are sent into the bathroom. If they don't urinate or scant amount, notify provider.

Weight:

- Pt changes into gown, removing all articles of clothing including undergarments (underwear, boxers, bra). Socks, stockings, and heavy jewelry should be taken off as well.
- If gowning is not feasible, pt wears light clothing, removing jewelry, shoes, sweatshirt, jacket, etc.
- Pt stands in front of scale, with back facing the numeric screen.
- When scale is zeroed, staff asks pt to step backwards onto the center of the scale. Once the weight has been determined, pt will step off the scale. Staff will zero the scale again to prevent pt from seeing their weight.
- Staff should always stay in the weight room with the pt. This prevents pts from weighing themselves or pressing the "weight recall" button located on the scale. This also decreases opportunities for pts to place items on their bodies to manipulate their weight. Advise provider if suspect a pt is manipulating their weight (abnormal movements or bulging, etc)

Height:

- Take height using the same stadiometer. Make sure pt stands flat up against the wall for accurate reading

Orthostatic vital signs (BP, HR)

- It is ideal to take these vital signs midday or afternoon as patients tend to be more orthostatic early in the morning.
- The exam table must be completely flat. The pt must be lying on their back with their legs fully extended (pull out the exam table footrest).
- Instruct pts to lay still and breathe normally for 5 minutes. Monitor for abnormal breathing patterns, movement of extremities, or any action that might increase their vital signs. It is preferred that pts do not engage in much discussion during this time to help ensure the most accurate readings.
- At the end of 5 minutes, take pt's BP & HR while lying (usually POCT urine dipstick done during five minutes of lying, unless pt needs more supervision) .
- Have the pt SLOWLY transition off the table to a standing position. Check that pt is not dizzy or lightheaded. The same instructions apply for this 2 minute interval. At the end of 2 minutes, take pt's BP & HR & TEMP.
- Perform POCT urine dipstick.

- Enter all vital signs and POCT results into the medical record.

NOTE: Do **not** allow pt to see weight, height or VS numbers as this can trigger eating disorder.

Admission Criteria for Medical Stabilization

Bradycardia	Daytime HR < 50/min or Nocturnal HR < 45/min
Hypotension	BP <90/45
Hypothermia	Temp<36 °C/ 96 °F
Orthostasis (supine→standing)	Pending review of case 35-point increase in HR or 20 mmHg decrease in systolic BP or 10 mmHg decrease in diastolic BP
Weight	<75% Estimated body weight on patient's historical growth curve
Electrolyte abnormality	• Phosphorus < 3.0 mg/dL • Potassium < 3.5 mmol/dL • Magnesium <1.8 mg/dL
EKG abnormality	Prolonged QTc >460 msec, Arrythmias
Other	Acute food refusal for 24-48 hours Syncope Seizures, heart failure, severe dehydration, GI bleeding, pancreatitis

For Providers:
If your patient meets criteria and you would like to request a bed at UCSF Benioff Children's Hospital (San Francisco, CA) please contact the Pediatric Access Center at 1-877-822-4453 or 1-877-822-UC-CHILD

Detecting Eating Disorders

- Despite common misperceptions, eating disorders do not discriminate:
    - Socioeconomic status is NOT associated with eating disorder presentation (Huryk et al., 2021)
        - Food insecurity can increase eating disorder risk
    - There are few group differences in eating disorder prevalence among racial and ethnic groups
    - However, minoritized individuals are significantly less likely than whites to have:
        - been asked by a doctor about eating disorder symptoms (Becker, 2003)
        - access to evidence-based care (Marques et al., 2011)
- Atypical Anorexia Nervosa, defined as meeting all of Anorexia Nervosa criteria except BMI being within normal range or overweight despite weight loss, can still result in significant medical complications (Garber et al., 2019) and requires restoration of nutrition and weight and re-establishing regular, flexible eating habits.
- Early signs of eating disorders:
    - Cutting back on food intake or skipping meals
    - Cutting out foods, becoming vegetarian or vegan
    - Exercising more
    - Making comments about body (often brought up by parents)
    - Reading recipe books, getting involved in cooking
    - Food going missing
    - Using bathroom frequently after meals / vomit residue in toilet or shower
- Later signs of eating disorders:
    - Weight loss or lack of normative weight/height increase (often no weight loss in young patients)
    - Loss of menses
    - Isolation from peers / family members
    - Vast quantities of food missing or hidden food wrappers (e.g., in bedroom, backpack)
    - Teeth decay / color change / swollen parotids
    - Calluses on hands (rare)

Outpatient Management of Eating Disorders

- If under treatment goal weight (TGW; see next section), frequent (weekly) follow-up for weight check, HR, BP, temperature weekly, until in TGW range or care established in an eating disorder program. May space out visits once gaining weight steadily or in TGW range.
- Refer to an eating disorder program and/or make referral to a therapist knowledgeable about eating disorder treatment (and/or dietician specialized in eating disorders if specialized ED therapist not available).
    - Family Based Treatment (FBT; AKA Maudsley Approach) for adolescents is the 1st-line evidence-based treatment modality for pediatric and adolescent eating disorders. Cognitive behavioral therapy (CBT) for eating disorders is also gaining evidence for use in adolescent eating disorders.
    - Higher levels of care (day treatment or residential programs) may be used if FBT or CBT is not available, or if behaviors are not able to be contained in the outpatient context
- Psychotropic Medication
    - SSRIs may be beneficial in treatment of comorbid anxiety, depression, OCD but no evidence for eating disorder symptoms or weight restoration. Typically not effective until individual is at least ~85% of TGW.
    - Bulimia Nervosa: In adult studies evidence for use of SSRI (Fluoxetine) + Cognitive behavioral therapy
- Other medication
    - Abdominal pain and bloating with meals from delayed gastric emptying that accompanies malnutrition may be relieved with pro-motility agents.
    - Constipation may be relieved with stool softeners.
    - Important to advise family to feed through abdominal discomfort. Regular nutrition is required for gut to return to normal functioning. With regular nutrition, abdominal discomfort associated with eating typically resolves within several weeks.
    - Liquids (e.g., milk, juice, smoothies, milkshakes) typically move through the gut faster than solids.
- Educate patient and family on medical complications, psychological symptoms, morbidity, mortality of eating disorders.
    - Medical complications: impacts all organ systems in the body. If weight loss or ED symptoms progress, medical hospitalization may be necessary.
    - Psychological symptoms: anxiety, depression, fear of weight gain, obsessionality, sleep difficulties, irritability
    - Morbidity/mortality: EDs carry the second highest (recently surpassed by Opioid Use Disorder) of any psychiatric illness. Early intervention, nutritional rehabilitation and reversal of eating disorder behaviors (e.g., cessation of purging) are best predictors of treatment outcome.

Estimating Treatment Goal Weight (TGW)

Note: Difficult thoughts, behaviors, and emotions associated with eating disorders (e.g., anxiety about eating, fear of weight gain, hypergymnasia, behaviors such as cutting food into tiny pieces) are a direct result of malnutrition. They cannot improve without nutritional and weight restoration. One of the best predictors of good treatment outcome in eating disorders is early weight gain. *Malnutrition can occur in individuals with any body size (including those in the obese and overweight range).*

Treatment goal weight (TGW), also known as estimated body weight (EBW), is a personalized, **estimated** target weight range for optimal recovery based on available growth records that takes into account normal expected growth in the next 12 months. This estimate may be greater than the individual's highest prior weight because weight gain is expected with normal growth and development, even after reaching one's adult height. TGW estimates are to be adjusted over time with increasing age and/or changes in height, or as additional information becomes available that further informs this estimate.

Youth 2-20 yrs:

- Return to historical growth trajectory (BMI) from age 4 on (unless historically below 5th percentile for BMI – in that case, calculate to 5th percentile)
    - E.g., Child tracked between 60-75th%ile for BMI from age 4 to age 13; began to lose weight at age 13.5 and is now 15. Calculate TGW for current height and age for a BMI at the ~68th%ile.
- If no historical records available or if former growth trajectory was abnormal, use median BMI (mBMI), which is the 50%ile BMI for age and sex on CDC growth charts for ages 2-20.
- If there is a lot of variation in growth history, consider what eating was like at various points (e.g., disordered eating, food insecurity)
- If well above the growth curve (e.g., >99th percentile for BMI) and losing weight, minimum goal is no further weight loss

Adults 20 years +:

- Extrapolate from historical growth charts if available. If not available:
    - Ask weight and height prior to weight loss, calculate associated BMI, and set TGW associated with that BMI *OR*
    - Use weight at last menses +5lbs (at minimum; this will likely be an underestimate)
- To calculate weight corresponding to e.g., BMI = 22kg/m^2:
        - BMI (22) x ht (m) x ht (m) = kg
        - Or use a BMI calculator or table

Nutrition

If weight gain is needed (based on TGW guide above):

- Goal: at least 1-2 lbs of weight gain per week. Some reputable eating disorders outpatient programs aim for 3-4 lbs per week.
    - Many individuals require ~2500-5000 kcal/day to achieve this goal due to metabolic changes during nutritional rehabilitation
- Recommend 3 meals per day and 3 snacks; each meal/snack should include a caloric beverage (e.g., milk, juice)
    - Snacks should be like small meals and contain more than one food group
- Favor calorically dense foods (fats, proteins, carbs); vegetables and fruits should be used as garnish or as a vehicle for fats (e.g., apples and peanut butter, carrots and dip) to minimize fullness and abdominal discomfort
- If caregivers leading renourishment (usually recommended): caregivers are 100% in charge of preparing and plating meals. Limit negotiation and discussion around meals and snacks. Limit child's presence in kitchen during meal preparation to limit negotiation.

If weight gain is not needed, but eating is irregular:

- Recommend 3 meals per day and 1+ snack, not going for more than 3-4 hours without eating when awake

All patients:

- Encourage caregivers to feed their child the foods that their family has always eaten.
    - Portions will need to be increased and fewer fruits/vegetables served, but they should not make special meals for the patient or accommodate eating disorder preferences.
    - Families do not all need to eat identical portions to that of the patient. Caregivers can say “everyone has different nutritional needs.”
    - However, it is helpful when everyone is eating the same foods when possible (e.g., caregivers should not consume diet foods in front of the child).
- Patient should return to eating all foods eaten prior to onset of disordered eating (e.g., if family eats chips and child recently began cutting out chips, child should begin eating chips again)
    - All food groups represented when possible
    - No diet foods: no sugar-free, low carb or low/non-fat
    - Caffeine not recommended.
- All meals and snacks (ideally) should be supervised by a trusted adult
    - Depending on school resources, a school nurse or counselor may be able to supervise lunch
- Meals should be limited to 30-45 minutes, snacks to 15-30 minutes
- Some families choose to use nutritional supplement drinks (e.g., Boost, Boost Plus, Ensure) to augment nutrition.
    - MediCal will typically cover if physician orders. General instructions (*Note: different DME companies have varying requirements (e.g., have different products, may or may not require product number), so trial and error may be required.)*:

1. Provider Orders Enteral Nutrition PO with order with Product details (product code amount per day). For example: Boost Plus Chocolate Product# 4390093239, (3) 8 fl oz containers per day, 720 ml in 24 hours, 21,600 ml per month for twelve months.
2. Fax the following to the Durable Medical Equipment (DME) Supplier that is covered by patient's insurance:
    - Enteral nutrition order
    - Clinical justification and ICD 10 Code (ie malnutrition, anorexia)
    - Growth charts
    - Recent clinical note

- If any concern for purging, patient should be monitored for 45-60 minutes after eating
    - Use bathroom prior to meal/snack
    - Bathroom/shower use not permitted during monitoring period; if bathroom necessary, door cracked and patient talking or singing to caregiver standing outside door
- If there is binge eating (any loss of control eating), there is typically some form of irregular or restrictive eating (e.g., caloric restriction or restriction of certain foods). Advise that patient not go for more than 3-4 hours without eating while awake
- Increased distress before/during/after eating is normal
- Remove scale from home. If needed for remote medical monitoring, hide between uses.
- Individuals may experience the following changes as they begin to eat normally:
    - Physical Changes:
        1. Gas and abdominal pain. This may be related to the body's adjustment to eating and the introduction to new foods. The only way to relieve this pain is to continue to "exercise" your gut muscle by continuing to eat.
        2. Bloating. Initially fluid retention can occur when increasing nutrition. This too will resolve as eating is normalized.
    - Changes in Thoughts and Feelings:
        1. Patients commonly experience or are more aware of unpleasant thoughts and feelings as they start to establish more regular eating habits. Common emotions include anxiety and anger.
        2. Encourage patient to engage in distracting activities (e.g., watch a favorite show, call a friend, play a game) when distressed

How to Increase Food Density

Basic principles

- Eat frequently (every 2-3 hours); 3 meals and 3 snacks
- Limit foods and beverages that are low in calories; make every bite and sip count towards good nutrition
- No surface should go "unslathered" (e.g., add nut butter, regular butter, mayonnaise, or other high density spreads to fruit, bread, etc)
- Eat a variety of foods from all food groups, including various colors, textures, and flavors
- Always take extra food while doing errands, traveling, or while waiting for appointments

"Boost" beverages

- Choose whole milk instead of nonfat or low fat milk
- Make "double-strength milk" by mixing 1 cup powdered milk with 1 quart of whole milk (to drink as a beverage)

- Add Carnation Instant Breakfast, malt mix, protein powder, or chocolate powder/syrup to milk, milkshakes, or smoothies
- Drink caloric beverages (e.g., fruit nectars, juice, Gatorade, lemonade, sweetened iced tea, whole milk, egg nog) instead of water
- Try nutrition supplements such as Ensure Plus, Boost Plus, and Pediasure

"Boost" food preparation

- Add powdered milk to sauces, gravies, soups, casseroles, meat loaf, puddings, scrambled eggs, hot cereals (e.g., cream of wheat), mashed potatoes, and pancakes, or baked goods
- Use whole milk instead of water to prepare cooked cereals and cream soups, top with heavy cream
- Use "double-strength milk" (see above) or coconut cream (full-fat, canned) to use in food preparation
- Use heavy cream on cereal, over fruit, in custards, egg dishes, or milkshakes.
- Use fruit juice instead of water when making Jell-O; make milk gelatin (gelatina de leche) with whole milk and sweetened condensed milk
- Add butter, margarine, or olive oil to vegetables, potatoes, pasta, rice, toast, rolls, muffins, pancakes, hot cereals, soups and other foods as desired
- Sauté foods in olive oil or ghee and fry foods in canola oil or vegetable oil
- Try cooking rice in coconut milk or coconut cream instead of water,
- Add extra heavy cream and grated cheese to polenta/grits
- Beat eggs with heavy cream and scramble in butter or olive oil, add shredded cheese

Toppings & add-ins

- Top shakes, desserts, fruits, and hot chocolate with whipped cream
- Add dried fruit, nuts/seeds, or dense granola as toppings on ice cream, full-fat yogurt, whole milk pudding or custard, cereals
- Add chopped dried fruit, nuts, and/or seeds to muffins/cakes, cookies, home-baked bread
- Add flaxmeal or wheat germ to pancake batter or baked goods, in oatmeal, on top of yogurt
- Top Mexican foods with grated cheese, guacamole, and sour cream
- Try sour cream on top of baked potatoes, refried beans, chili, or mixed with brown sugar to top fruit or fruit cobbler/crumble/pie
- Sprinkle cheese on top of foods, or mix into foods Add cheese to sandwiches, burgers, toast; grate cheese on top of foods (eggs, chili, potatoes, pasta, vegetables, salads), and mix into soups
- Order extra cheese on pizza, tacos, and burgers
- Add chopped hard-boiled eggs, beans (e.g., kidney, garbanzo), nuts/seeds, and/or creamy cheese (goat cheese, full-fat feta, whole milk ricotta) to salads
- Add an extra egg to pancake batter or ground meat before cooking; dip chicken or fish in beaten egg before breading
- Add extra butter/margarine and grated cheese to macaroni & cheese, scalloped potatoes, and other side dishes
- Use jelly, jam, or honey on toast or add to hot and cold cereals and yogurt

Sauces & condiments

- Serve gravies and cream sauces with meats and vegetables or other foods such as rice, noodles, biscuits, and potatoes

- Add sauces to cheese-based pasta dishes (e.g., ravioli, lasagna) or over cooked vegetables (broccoli, cauliflower), including cheese sauce, Alfredo sauce, Vodka sauce, béchamel, cream sauce, and pesto
- Serve veggies or salad with cream-based dressings (e.g., blue cheese, ranch)

Additional dense food ideas

- Choose from multiple meats, including as beef (including 85/15 ground beef), lamb, pork, chicken, dip in egg and fry (chicken fingers) when possible
- Serve fatty fish, such as salmon
- Frozen pizza, burritos, casseroles, enchiladas, tamales, pot pies, and quiche make easy meals
- Choose hearty soups, such as chowders (e.g., clam chowder, lobster bisque), cream-based soups (cream of mushroom, cream of corn, cream of chicken), and bean/legume soups (split pea, lentil, navy bean, minestrone)
- Order a side of onion rings
- Order a side of fried rice, pot stickers, scallion pancakes, egg rolls, or wontons
- Extra-cheesy grilled cheese sandwich on heavily buttered, dense bread
- Choose starchy vegetables/fruits, such as potatoes (hash browns, French fries, roasted potatoes, creamy mashed potatoes), parsnips, pumpkin, corn, and plantains/banana

High Density Snack Ideas

Savory snacks

- Bagel with thick layer of cream cheese with juice or nectar
- Tortilla chips with guacamole or black bean dip with sour cream
- Pita chips with hummus (stir in extra olive oil)
- Veggies with ranch/blue cheese dressing or other sour cream-based dressing
- Extra cheesy quesadilla with guacamole and sour cream
- Trail mix (dried fruit, nuts, seeds, chocolate chips/M&Ms, coconut)
- Chex Mix with extra nuts
- String cheese (full-fat) with hard boiled eggs and juice
- Cheese and crackers (Ritz or whole grain) with Naked smoothie
- Ants on a log (celery with peanut butter and raisins)
- Mini pizza on English muffin with tomato sauce, full-fat mozzarella cheese, and olives
- Popcorn with butter and parmesan cheese
- Baked potato topped with butter, cheese, sour cream, and bacon bits
- Avocado toast (at least ½ avocado)
- Peanut butter filled pretzels
- Deviled eggs
- Peanut butter and jelly sandwich
- Fried potato skins, mozzarella sticks, jalapeño poppers, cheese filled bread sticks, fried zucchini, or tempura with ranch dip, blue cheese dressing, and/or marinara sauce
- Protein bar (Luna, Lara, Clif, Kind) or dense granola bar (RxBar) with fruit and/or whole milk
- Egg or chicken salad on crackers, croissant, dinner rolls, or pita bread with melted cheese
- Tuna or salmon (canned in oil) with crackers
- Cornbread, savory biscuit, or croissant with butter, and/or jam or honey, and/or cheese
- Nachos piled with cheese, beans, meat, sour cream, guacamole, salsa, and olives

- Fried potato latkes with sour cream and apple sauce
- Spanakopita or samosas

Sweet snacks

- Parfait (whole milk yogurt, cottage cheese, ricotta cheese, or whipped cream with berries and nut/seed/dried fruit granola)
- Banana bread or pumpkin bread with whole milk
- Milkshake or smoothie (can add Carnation Instant Breakfast, nut/seed butter, Nutella, honey, wheat germ, chia seed, etc)
- Graham crackers with peanut butter (or other nut/seed butter) and jelly
- Fruit (apple, banana) with peanut butter (or other nut/seed butter)
- Cookies or candies made with nuts/seeds (e.g., Aussie Bites) with whole milk
- Coconut clusters with fruit nectar (e.g., mango, peach, apricot)
- Waffles, pancakes, or French toast with butter and honey/syrup, Nutella and banana, or berries and whipped cream
- Ice cream or full fat frozen yogurt topped with fudge, whipped cream, berries or banana, and granola/chopped nuts or chopped candy (e.g., peanut butter cups)
- Full fat pudding or custard topped with fruit or crumbled cookies and whipped cream
- Large muffin or cupcake, or slice of frosted cake with whole milk· Ice cream cookie sandwich or chocolate covered ice cream bar
- Fruit cobber or crisp topped with vanilla ice cream or whipped cream
- Danish, puff pastries, croissants, scones, or turnovers
- Churros or flan
- Chocolate-covered nuts or dried fruit
- Hot chocolate with marshmallows and whipped cream

How to Guide Families

- For children and adolescents with eating disorders family involvement and treatment are essential. Make it clear that the eating disorder is not the caregivers' fault. Eating disorders are genetic and brain-based.
- Individuals with eating disorders typically are not able to make appropriate choices with respect to eating behaviors, and *needs the caregivers' help to get back on track*.
    - Food is medicine. Recommend that caregivers be put in charge of nutrition. They decide what, how much, and when the child eats. The child's only job is to eat the food.
        - Recommend that the patient not observe cooking (e.g., out of view of the kitchen)
        - Avoid negotiating about meals/food choices as the eating disorder takes over the patient's ability to make good choices
- Regular, flexible eating (including all food groups and foods that the eating disorder has cut out) and restoring weight essential in improving patient's mood, insight, and behaviors
    - Encourage patients and families that there are no good and bad foods. Patient should return to eating all foods that they ate prior to the onset of the disordered eating, even if they state that they no longer like that food.
- When caregivers are frustrated, remind them that the illness is challenging them, not the child, and they should focus on combating the eating disorder not their teen.
- Parents may need education on their child's treatment goal weight range and nutritional needs.
- Parents and providers should refrain from making comments about their own/others' bodies.

Tips for Providers

- ED symptoms can be associated with shame, so disclosure should be treated sensitively, empathically, and non-judgmentally
- Benign comments can be loaded:
    - "You look so healthy" = "Whoa, you've gained a ton of weight"
    - "You look fantastic" = "Wow, you're so fat"
    - "You're made so much progress" = "You're failing, you shouldn't be going along with this plan to eat so much food"
    - Recommend not commenting on patient appearance
- Do not collude with the eating disorder (e.g., don't tell someone it makes sense that they are worried about becoming overweight)
- Adolescents may not like their eating disorder therapist very much and are likely to be resistant to therapy because changing ED behaviors is challenging.
- Changing eating disorder behaviors is often associated with distress – it is a normal part of the process.

Educational Resources for Providers

Hornberger LL, Lane MA, AAP THE COMMITTEE ON ADOLESCENCE
Clinical Report – Identification and Management of Eating disorders in Children and Adolescents. American Academy of Pediatrics. Pediatrics 2021;147(1): e2020040279
https://doi.org/10.1542/peds.2020-040279

Katzman DK, Peebles R, Sawyer S et al.
The Role of the Pediatrician in Family-Based Treatment for Adolescent Eating Disorders: Opportunities and Challenges
Journal of Adolescent Health. 2013 Oct;53(4):433-40.
http://dx.doi.org/10.1016/j.jadohealth.2013.07.011

Academy for Eating Disorders (AED) Medical Care Standards Guide – The Purple Book
https://www.aedweb.org/publications/medical-care-standards

Tips for Parents

- Educate yourself on eating disorders
- Remind your child they have people who care and support them
- Be Honest: Talk openly about your concerns
    - Avoiding or ignoring will not help the situation
    - Use first person "I" statements to convey your concerns (ie "I have noticed you haven't been joining us for dinner lately", "I am worried about your health")
    - Listen openly, share your concerns by describing the facts you observed
- Stay firm toward the eating disorder and warm toward your child (e.g., "I see how hard this is for you, and I'm right here with you. I need you to finish your dinner.")
- Keep some normalcy with family routines
- Ask for and accept help as eating disorders can take an emotional toll on the entire family
- Best outcomes occur when all caregivers are on the same page
- Recovery takes time. Be patient and stay away from placing blame or guilt on family members

Resources for Families

Websites

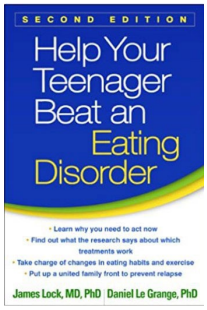
NEDA (National Eating Disorder Association)
https://www.nationaleatingdisorders.org/learn/help/caregivers
The National Eating Disorder Association (NEDA) is the largest non-profit organization dedicated to supporting individuals and families affected by eating disorders providing education, toolkits for parents, help and support.

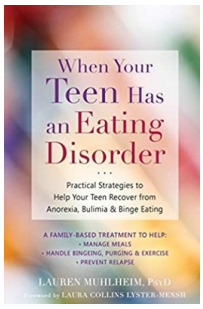
F.E.A.S.T. (Families Empowered and Supporting Treatment of Eating Disorders)
https://www.feast-ed.org/
A non-profit global online support group of parents and volunteers connected by their common experiences offering education, resources, advocacy, and family support. Includes:

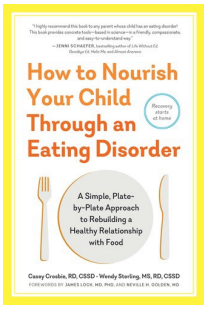
- Family Guide Series on the FEAST website (set of family guides (10-12 page informational PDFs): https://www.feast-ed.org/family-guide-series/
- E.D. First 30 Days Program (Daily emails from FEAST parent's organization with approximately 30 minutes of learning material per day - including reading, video, audio content): https://www.feast-ed.org/register-now-for-our-30-day-educational-service/

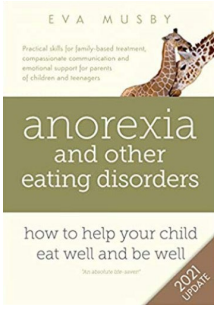
Maudsley Parents
http://www.maudsleyparents.org/
Offers information on eating disorders, family based treatment, family stories of recovery, supportive parent-to-parent advice

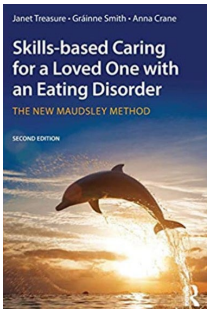
Books











Recovery Guides:

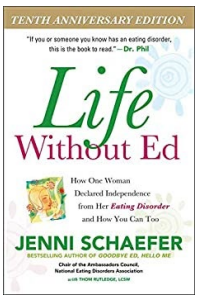
- Help Your Teenager Beat an Eating Disorder by Lock & Le Grange
- When Your Teen has an Eating Disorder by Lauren Muhlheim
- How to Nourish Your Child Through an Eating Disorder: A Simple, Plate-by-Plate Approach to Rebuilding a Healthy Relationship with Food by Casey Crosbie and Wendy Sterling
- Anorexia and other eating disorders by Eva Musby
- Skill-based Caring for a Loved One with an Eating Disorder by J. Treasure, G. Smith and A. Crane

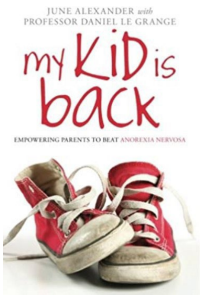
Personal Accounts:

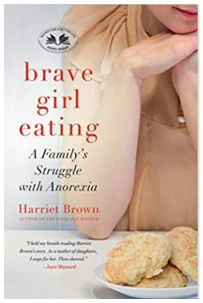
- Life Without ED by Jenni Schaefer
- My Kid is back: Empowering parents to beat Anorexia Nervosa by June Alexander & Daniel Le Grange
- Brave Girl Eating: A Family's Struggle with Anorexia by Harriet Brown

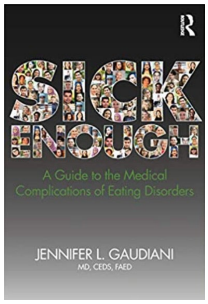
Guide to medical complications associated with eating disorders:

- Sick Enough by Jennifer Gaudiani, MD









Video Resources

Eating Disorders Meal Support: Helpful Approaches for Families by the Provincial Specialized ED Program: https://www.youtube.com/watch?v=pPSLdUUITWE

Modelling Support by Janet Treasure: https://www.youtube.com/watch?v=5jHXcUeOgTk

Video and Audio resources by Eva Musby: https://anorexiafamily.com/videos-eating-disorder-anxiety-child/?v=7516fd43adaa

Podcast Episodes

Parenting a Child Through an ED - JD Ouellette
Part 1:
https://eatingdisorderrecoverypodcast.podbean.com/e/jd-ouellette-on-parenting-a-child-through-an-eating-disorder-%e2%80%94-part-one/
Part 2:
https://eatingdisorderrecoverypodcast.podbean.com/e/jd-ouellette-on-parenting-a-child-through-an-eating-disorder-%e2%80%94-part-two/

7 Tips For Getting A Person With An Eating Disorder To Eat With Eva Musby:
https://eatingdisorderrecoverypodcast.podbean.com/e/7-tips-for-getting-a-person-with-an-eating-disorder-to-eat-with-eva-musby/

Perspective of a teen who has gone through FBT: How Family Based Therapy Saved my Life:
https://eatingdisorderrecoverypodcast.podbean.com/?s=how+family-based+therapy

Referral Resources

Multidisciplinary Outpatient Care and Inpatient Medical Stabilization (Youth and Young Adults):

UC San Francisco Eating Disorders Program
https://eatingdisorders.ucsf.edu/
Initial Outpatient appointments: 415-514-1074
Health care providers referring to UCSF for medical stabilization: 877-822-4453
Offered specialized medical and nutrition care, and consultation with a mental health provider. Intensive mental health evaluation and treatment are available, but there is typically a wait of several months or more.

Stanford Eating Disorders Program
https://www.stanfordchildrens.org/en/service/eating-disorders-program Initial outpatient appointments: 650-723-5511
Health care providers referring to Stanford for medical stabilization: 650-988-8381

Virtual Multidisciplinary Outpatient Care (Youth and Young Adults):

Equip Health
https://equip.health/

In many communities, other therapy resources (e.g., therapists in private or group practice) are also available.

Eating Disorders Higher Level of Care Referrals for Adolescents

IOP and PHP Programs in California

Healthy Teen Project - IOP/PHP
(650)-941-2300
Los Altos, CA
San Francisco, CA
http://www.healthyteenproject.com

Eating Recovery Center of CA - IOP/PHP
1-877-920-2902
Sacramento, CA
https://www.eatingrecoverycenter.com

Lotus Collaborative - IOP/PHP
415-886-1753
San Francisco, CA

Santa Cruz, CA
http://www.thelotuscollaborative.com

Cielo House – IOP/PHP
650-455-9242
Belmont, CA
Moss Beach, CA
San Jose, CA
https://www.cielohouse.com/

LGTC Group – IOP/PHP
408-215-7066
Virtual, Burlingame, CA and Campbell, CA
https://www.lgtcgroup.com/eating-disorder-programs/

UC San Diego Eating Disorders Center
http://eatingdisorders.ucsd.edu/
Partial Hospitalization, Intensive Outpatient Program: 858-534-8019

Center for Discovery
https://centerfordiscovery.com/
Intensive outpatient, Partial Hospitalization, Residential Treatment: 866-482-3876

Residential Programs in the Bay Area

Sunol Hills – 30 to 90 day residential treatment for ages 11-17
855-265-2244
Lafayette, CA

Center for Discovery
https://centerfordiscovery.com/
Intensive outpatient, Partial Hospitalization, Residential Treatment: 866-482-3876

LGTC Group – Residential
408-215-7066
Campbell, CA
https://www.lgtcgroup.com/eating-disorder-programs/

Residential Programs in the United States

Eating Recovery Center Denver
https://www.eatingrecoverycenter.com/

Veritas Collaborative
Southeastern US – several locations

https://veritascollaborative.com/contact-us/

Clementine
Various Locations inside and outside of California
http://clementineprograms.com/

Center for Change
Orem, Utah
https://centerforchange.com/treatment/levels-of-care/residential-treatment/
888-224-8250

Center for Hope of the Sierras (Eating disorder specific treatment for age 16 and up)
Reno, Nevada
https://www.centerforhopeofthesierras.com/

Inpatient Programs

Alta Bates
(510) 204-4405
Berkeley, CA
http://www.altabatessummit.org/eatingdisorders/

UCLA Inpatient Therapeutic Program
https://www.uclahealth.org/eatingdisorders/inpatient-therapeutic-program

Reasons
Los Angeles, CA (and other locations)
https://reasonsedc.com/

Eating Disorders Higher Level of Care Referrals for Adults

IOP and PHP Programs in the Bay Area

Alta Bates Summit Center for Anorexia and Bulimia - IOP/PHP (adults)
(510) 204-4069
Berkeley, CA
http://www.altabatessummit.org/eatingdisorders/

Eating Recovery Center of CA - IOP/PHP
1-877-920-2902
Sacramento, CA
https://www.eatingrecoverycenter.com

Lotus Collaborative - IOP/PHP

415-886-1753
San Francisco, CA
Santa Cruz, CA
http://www.thelotuscollaborative.com

Cielo House – IOP/PHP
650-455-9242
Belmont, CA
Moss Beach, CA
San Jose, CA
https://www.cielohouse.com/

LGTC Group – IOP/PHP
408-215-7066
Virtual and Campbell, CA
https://www.lgtcgroup.com/eating-disorder-programs/

Center for Discovery
https://centerfordiscovery.com/
Intensive outpatient, Partial Hospitalization, Residential Treatment: 866-482-3876

Residential Programs in the Bay Area

Cielo House – Moss Beach
650-455-9242
323 Cypress Ave
Moss Beach CA
https://www.cielohouse.com/contact-us

Alsana – Monarch Cove
888-822-8938
Monterey, CA
https://www.alsana.com/monterey-california/

Monte Nido – East Bay
888-891-2590
Walnut Creek, CA
https://www.montenido.com/locations/east-bay-ca/

Center for Discovery
https://centerfordiscovery.com/
Intensive outpatient, Partial Hospitalization, Residential Treatment: 866-482-3876

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888-224-8250

Center for Hope of the Sierras (Eating disorder specific treatment for age 16 and up)
Reno, Nevada
https://www.centerforhopeofthesierras.com/

Reasons (adults)
844-573-2766
Los Angeles, CA (and other locations)
https://reasonsedc.com/

Inpatient Programs

Alta Bates
(510) 204-4405
Berkeley, CA
http://www.altabatessummit.org/eatingdisorders/

UCLA Inpatient Therapeutic Program
https://www.uclahealth.org/eatingdisorders/inpatient-therapeutic-program

Reasons
844-573-2766
Los Angeles, CA (and other locations)
https://reasonsedc.com/

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