A Guide to Selecting Evidence-based **Psychological Therapies** for Eating Disorders

Academy for Eating Disorders®
(First edition, 2020)

AED®

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DISCLAIMER: This document, created by the Academy for Eating Disorders' Psychological Care Guidelines Task Force, is intended as a resource to promote the use of evidence-based psychological treatments for eating disorders. It is not a comprehensive clinical guide. Every attempt was made to provide information based on the best available evidence. For further resources, visit: www.aedweb.org

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Background

All eating disorders (EDs) are serious mental illnesses with significant, life-threatening medical and psychiatric morbidity and mortality, regardless of an individual's weight. Patients with EDs have among the highest case fatality rate (i.e., the proportion of all individuals diagnosed with a disorder who die) of any psychiatric condition For example, the risk of premature death is 6-12 times higher in women with Anorexia Nervosa (AN) as compared to the general population, adjusting for age.

Early recognition and timely intervention, based on a developmentally appropriate, evidence-based, multidisciplinary team approach (medical, psychological & nutritional) is the ideal standard of care. Members of the multidisciplinary team may vary and will depend upon the needs of the patient and the availability of these team members in the patient's community. In communities where resources are lacking, clinicians, therapists, and dietitians are encouraged to consult with the Academy for Eating Disorders (AED) and/or ED experts in their respective fields of practice.

Eating Disorders

For the purpose of this document, we will focus on the most common EDs including:

1. **Avoidant/Restrictive Food Intake Disorder (ARFID):** Significant weight loss, nutritional deficiency, dependence on nutritional supplement or marked interference with psychosocial functioning due to caloric and/or nutrient restriction, but without weight or shape concerns.

2. **Anorexia Nervosa (AN):** Restriction of energy intake relative to an individual's requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory and health status. Disturbance of body image, an intense fear of gaining weight, lack of recognition of the seriousness of the illness, and/or behaviors that interfere with weight gain are also present.

3. **Bulimia Nervosa (BN):** Binge eating (eating a large amount of food in a relatively short period of time with a concomitant sense of loss of control) with purging/compensatory behavior (e.g., self-induced vomiting, laxative or diuretic abuse, insulin misuse, excessive exercise, diet pills) once a week or more for at least 3 months. Disturbance of body image, an intense fear of gaining weight and lack of recognition of the seriousness of the illness may also be present.

4. **Binge-Eating Disorder (BED):** Binge eating, in the absence of compensatory behavior, once a week for at least 3 months. Binge eating episodes are associated with eating rapidly, when not hungry, until extreme fullness, and/or associated with depression, shame or guilt.

5. **Other Specified Feeding and Eating Disorder (OSFED):** An ED that does not meet full criteria for one of the above categories, but has specific disordered eating behaviors such as restricting intake, purging and/or binge eating as key features. Examples include purging disorder and night eating syndrome.

6. **Unspecified Feeding or Eating Disorder (UFED):** ED behaviors are present, but they are not specified by the care provider.

Consult www.aedweb.org, DSM-5, or ICD-10 for full diagnostic descriptions.

Important Facts about Eating Disorders

- All EDs are serious disorders with life-threatening physical and psychological complications.
- All EDs can be associated with serious medical complications affecting every organ system of the body.
- The medical consequences of EDs can go unrecognized, even by an experienced clinician.
- EDs do not discriminate. They can affect individuals of all ages, genders, ethnicities, socioeconomic backgrounds, and with a variety of body shapes, weights and sizes.
- Weight is not the only clinical marker of an ED. People who are at low, normal or high weights can have an ED, and individuals at any weight may be malnourished and/or engaging in unhealthy weight control practices.
- Individuals with an ED might not recognize the seriousness of their illness and/or may be ambivalent about changing their eating or other behaviors.
- All instances of precipitous weight loss or gain in otherwise healthy individuals should be investigated for the possibility of an ED, as rapid weight fluctuations can be a potential marker of an ED.
- In children and adolescents, failure to gain expected weight or height, and/or delayed or interrupted pubertal development, should be investigated for the possibility of an ED.

Purpose of this Guide

The Academy for Eating Disorders (AED) is committed to ensuring that individuals with eating disorders and their carers should have access to the best treatment available. The nature of eating disorders means that their treatment requires attention to both physical and psychological needs. The AED's ***Eating Disorders: A Guide to Medical Care*** (2016; 3rd Edition) outlines the medical care of such individuals. This guide is the companion piece to that medical care guide.

This guide is based on evidence regarding effective psychological treatment of eating disorders. It is the first international guide on evidence-based psychotherapeutic interventions for eating disorders, designed to inform clinicians anywhere in the world, particularly in locations without their own guidelines or without up-to-date guidelines.

This document identifies the best psychological therapies for eating disorders, based on a synthesis of many separate guidelines. The AED believes that therapists, supervisors, managers, commissioners, patients, and their carers should have access to this information to assist in choice, delivery, and training. However, clinicians should be aware that this guide is not a substitute for undertaking appropriate training in these manualized interventions or for adhering to the methods they describe.

A Note to Patients and Their Loved Ones and Policymakers

This is the first international guide for psychological treatment of eating disorders. It is compiled based on published national treatment standards from seven countries and represents the current research-guided evidence-base for treatment by psychologists and mental healthcare providers. It is best used as a companion to the AED's ***Eating Disorders: A Guide to Medical Care*** (2016; 3rd Edition), which covers the medical aspects of eating disorder management.

The AED is the leading scientific and training organization in the world focusing on eating disorders. As a multi-disciplinary community of clinicians, researchers, and advocates, we understand the importance of providing authoritative information to those treating, researching, supporting, and living with eating disorders. We understand the urgency for disseminating new research while respecting the clinical judgement and real-world knowledge in the field. This guide is meant to offer a view of the evidence that will be used alongside experience and training to help patients, their families, and policymakers.

While these guidelines are meant to inform treatment decisions by psychological treatment providers, we also hope to inform allied professionals who are supporting treatment teams, and to help patients and their families understand if and how their treatment options are supported by the literature. Policymakers, too, can be informed about which treatments are supported by evidence, and therefore, where legislative attention is most warranted. We also hope, by showing what is known, to spotlight what is yet unknown and where research is critically needed.

This guide is based on existing national guidelines published since 2010, which were developed using the research-based literature. Because the evidence base for comparing or evaluating eating disorder treatment remains limited in breadth and strength, this guide can be considered a composite of snapshots, not a full picture. It does not include recommendations based on clinical judgement or current practice, or cover the full range of eating disorder diagnoses or types of people affected. This document covers treatment modalities only, not settings, or level of care. There is little existing treatment research on some eating disorder diagnoses, and evidence by gender, culture, and age is often lacking, such that few recommendations exist at such a fine grained level. The solution — more research — is a long-term goal we all hope to promote. We plan to update the guide to incorporate new findings, and expect this guide to evolve as more high-quality evidence emerges.

This guide does not include all existing treatments or approaches, only those that have been methodically researched and found to be comparatively effective. The treatment modalities listed are only one aspect of the professional, personal, and community support for those struggling with these dangerous but treatable disorders. Where no recommendations exist for a diagnosis, it is generally accepted to adapt the treatments best supported for the closest diagnosis.

For example, for individuals with OSFED, psychological approaches for anorexia nervosa or bulimia nervosa are often adapted, based on the patient's specific symptoms. Treatments are also often drawn from similar non-eating disorder diagnoses, such as with ARFID, where there are no published national guidelines, but clinicians can draw from the literature on anorexia nervosa, sensory processing disorders, and anxiety disorders.

Similarly, most national guidelines consider young people and adults separately. Where there are no recommendations for younger patients, adapting the evidence-based treatment for adults is often employed. The lack of research base for the full spectrum of eating disorders, ages, and contributing factors requires clinicians and policy makers to extrapolate from what is known. Unless stated, very few treatment approaches in these guidelines are contraindicated for similar diagnoses or ages.

Evidence-based guidelines for psychological therapies for eating disorders

A synthesis of multiple national guidelines appears below, organized by developmental stage (children/adolescents; adults) and diagnosis. There are a number of areas where there is currently no evidence-based recommendation made for any psychological therapy. In particular, this applies to the more recently defined and more diverse disorders (OSFED and ARFID). In such cases, the most common recommendation in national guidelines is to treat the individual as if they had the most similar specific eating disorder.

The evidence-based recommendations from the seven national guidelines used to create the synthesized recommendations here are summarized below, and detailed in the Appendix. In order to understand how those source recommendations were reached, the reader is encouraged to consult the specific national guidelines themselves.

Recommendations for Children and Adolescents

	FIRST LINE TREATMENTS	SECOND LINE TREATMENTS
Anorexia nervosa	FBT	AFT
Bulimia nervosa	FBT; CBT-ED	None
Binge-eating disorder	None	CBTgsh; CBT-ED individual or group
ARFID, Pica, Rumination, OSFED, UFED	None	None

Recommendations for Adults

	FIRST LINE TREATMENTS	SECOND LINE TREATMENTS
Anorexia nervosa	CBT-ED; MANTRA; SSCM	Focal Psychodynamic Psychotherapy
Bulimia nervosa	CBT-ED; CBTgsh	IPT; Group psychotherapy
Binge-eating disorder	CBT-ED group or individual; CBTgsh	IPT
ARFID, Pica, Rumination, OSFED, UFED	None	None

AFT = Adolescent-Focused Therapy
CBT = Cognitive-behavioral Therapy
CBT-ED = Cognitive-Behavioral Therapy for Eating Disorders
CBTgsh = Guided Self-Help Cognitive-Behavioral Therapy
FBT = Family-Based Treatment
FPT = Focal Psychodynamic Therapy
IPT = Interpersonal Psychotherapy
MANTRA = Maudsley Model of Anorexia Nervosa Treatment for Adults
SSCM = Specialist Supportive Clinical Management

Recommendations for Special Populations

There are no evidence-supported recommendations that would justify exceptions being made for young people or adults based on:

- gender
- disability
- sociocultural background
- race
- ethnicity
- socioeconomic status
- sexual orientation
- sexual identity
- weight status
- psychological co-morbidity (e.g., mood, anxiety, post traumatic stress disorder, obsessive compulsive disorder, personality disorder, substance use disorder)
- physical comorbidity
- chronicity of illness
- trauma
- religion

Training and Other Resources

Manuals and Selected Original Research

Agras W. S. & Apple, R. (2007). *Overcoming your eating disorder: A cognitive-behavioral therapy approach for bulimia nervosa and binge-eating disorder, guided self-help workbook.* Oxford University Press.

Fairburn, C. G. (2008). *Cognitive Behavior Therapy and Eating Disorders.* Guilford Press.

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Schmidt, U., Magill, N., Renwick, B., et al. (2015). The Maudsley Outpatient Study of Treatments for Anorexia Nervosa and Related Conditions (MOSAIC): Comparison of the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) with specialist supportive clinical management (SSCM) in outpatients with broadly defined anorexia nervosa: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 83(4)*, 796 – 807.

Waller, G., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountford, V., & Russell, K. (2007). *Cognitive Behavioral Therapy for Eating Disorders.* Cambridge University Press.

Training Resources

The **National Center of Excellence for Eating Disorders (NCEED)**: a SAMHA-funded initiative to provide resources to the public: www.nceedus.org

The **Centre for Research on Eating Disorders at Oxford (CREDO)**: the academic home of Cognitive Behavior Therapy – Enhanced (CBT-E) for Eating Disorders with resources for health professionals, including in-session guides and handouts: www.credo-oxford.com

Training in CBT-E: https://www.cbte.co/for-professionals/training-in-cbt-e/

Training in IPT for eating disorders: http://iptfored.com/home

Webinars, videos, and other resources: www.aedweb.org

More general informational videos: https://eatingdisorders.dukehealth.org/education

Development of this Guide

There are numerous national guidelines for the evidence-based psychological treatment of eating disorders, developed in different countries and at different times. However, some guidelines vary in their recommendations in important ways, often due to methodological issues (e.g., the emphasis given to clinical expert opinion; date of evidence-collection; context, economic considerations and amount

of evidence needed to support a conclusion). The aim of this guideline was not to re-review the source literature, but to review and synthesize the existing guidelines.

The AED convened a special Task Force, selected from an international group of AED members, including clinicians, researchers, and user/family representatives. They reviewed all available national guidelines found by searching electronic databases, the National Guideline Clearinghouse and the International Guideline Library, and outreach to colleagues, who provided translations where necessary. Guidelines published from 2010 onwards were included, as earlier guidelines were likely to be based on outdated evidence. This resulted in seven national guidelines from eight countries (Australia/New Zealand, Denmark, France, Germany, Netherlands, United Kingdom, and United States). The Task Force sought to identify common evidence-based recommendations and synthesize them to form this document. Recommendations based on clinical opinion alone are reported in the Appendix but are not advocated here due to their lack of evidence.

While the AED does not discount the potential value of clinician judgement in supplementing evidence-based psychological therapies, it should be stressed that there is very clear evidence from the wider field of psychological therapies that clinician judgement results in substantially poorer outcomes for patients, if that judgement is allowed to override the evidence-based approach (e.g., Bell & Mellor, 2009). In short, as Wilson (1996) has pointed out, clinician judgment is most useful when it is used to decide how to apply the evidence-based approach to the individual patient.

This guide does not distinguish the wide range of settings where eating disorder treatment takes place, because there is limited evidence that addresses evidence-based psychological therapies delivered in settings other than outpatient services. However, given that psychological treatment of eating disorders is effective in routine clinical practice (provided it adheres to the protocols tested in research settings), these conclusions and recommendations can be assumed to apply to most clinical practice.

While the methodology behind this guide means that its core conclusions are likely to remain unchanged for several years, much research is needed in some key areas. For example, the evidence base for psychological treatments for Avoidant Restrictive Food Intake Disorder (ARFID) and Other Specified Feeding and Eating Disorder (OSFED) are insufficient to guide confident recommendations about treating these presentations. It is also important to consider the potential of briefer therapies to be effective, in order to ensure wider access to evidence-based therapies (e.g., NICE, 2017; Waller et al., 2018).

This document has been approved by the AED Board of Directors as representing the AED's recommendation for current best practice in the delivery of psychological therapies for eating disorders. The AED intends to update this guide regularly to keep it current, as new evidence and updated national guidelines emerge.

Guidelines used to create this document

Australia and **New Zealand** guidelines published by the Royal Australian and New Zealand College of Psychiatrists (https://www.ranzcp.org/practice-education/guidelines-and-resources-for-practice/eating-disorders-cpg-and-associated-resources)

Denmark guidelines published by the Danish Health Authority (2016) for anorexia nervosa (https://www.sst.dk/da/udgivelser/2016/~/media/36D31B378C164922BCD96573749AA206.ashx) and bulimia nervosa (https://www.sst.dk/-/media/Udgivelser/2015/NKR-Bulimi/EN_194413_Quick-Guide-NKR-Bulimi_print.ashx?la=da&hash=54B13E57E7515B317B889C-CFD1B9F7725F72C69F)

French guidelines published by Haute Autorite´ de Sante´ (https://www.has-sante.fr/plugins/ModuleXitiKLEE/types/FileDocument/doXiti.jsp?id=c_1546479)

German guidelines published by the Association of the Scientific Medical Societies (https://www.awmf.org/leitlinien/detail/ll/051-026.html)

Netherlands guidelines published by the Dutch Foundation for Quality Development in Mental Healthcare (https://www.ggzstandaarden.nl/zorgstandaarden/eetstoornissen/introductie)

United Kingdom guidelines published by the National Institute for Health and Care Excellence (https://www.nice.org.uk/guidance/ng69)

United States guidelines published by the American Psychiatric Association (http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf)

See also Hilbert, Hoek, and Schmidt (2017) for additional information on eating disorder treatment guidelines across countries.

Appendix

Evidence-Based Psychological Therapies for Children and Adolescents

COUNTRY	EVIDENCE-BASED RECOMMENDED FIRST-LINE THERAPY	EVIDENCE-BASED SECOND-LINE THERAPY	UNEVIDENCED ALTERNATIVE POSSIBILITIES, WEAK RECOMMENDATION, CLINICAL CONSENSUS	PRIMARY OUTCOME VARIABLES	SECONDARY OUTCOME VARIABLES	SOURCE OF EVIDENCE
ANOREXIA NERVOSA						
UK	FBT; AFT			BMI, eating attitudes, body image, bulimic behaviors	Quality of life, anxiety, depression	NICE 2017
Germany	FBT			BMI		AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders
France		Family therapies				HAS Clinical Practice Guidelines
Denmark	FBT-AN		Consider adding physical exercise during weight gain phase	Weight gain (using specific targets), eating disorder symptoms assessed across therapy	Additional focus on broader symptoms (unspecified), normalize weight to 50th centile or to previous point on growth curve	Danish Health Authority 2016
Australia and New Zealand	FBT (manualized)	Alternate family-based approach; Adolescent-Focused Therapy	Avoid 'treatment as usual' approach	Weight gain, biological normalization	Dietary change, enhanced body image, reduced compensatory behaviors	RANZCP guideline 2014
USA	FBT-AN		Avoid conjoint family therapy where there are high levels of parental criticism			APA Practice Guideline 2012
Netherlands	FBT	CBT-ED; Adolescent Focused Therapy				Practice guideline for the treatment of eating disorders 2017
BULIMIA NERVOSA						
UK	FBT; CBT-ED			Eating attitudes, body image; bulimic behaviors	Quality of life, anxiety, depression	NICE 2017
Germany	Age-adapted CBT	FBT		Abstinence from binge eating and compensatory behaviors, remission from bulimia nervosa, reduction of symptom severity	Eating pathology, depression	AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders

Evidence-Based Psychological Therapies for Children and Adolescents (continued)

COUNTRY	EVIDENCE-BASED RECOMMENDED FIRST-LINE THERAPY	EVIDENCE-BASED SECOND-LINE THERAPY	UNEVIDENCED ALTERNATIVE POSSIBILITIES, WEAK RECOMMENDATION, CLINICAL CONSENSUS	PRIMARY OUTCOME VARIABLES	SECONDARY OUTCOME VARIABLES	SOURCE OF EVIDENCE
BULIMIA NERVOSA (continued)						
Denmark	CBT-BN; FBT-BN	Individual or group psychotherapy	Do not use motivational enhancement therapy	Eating disorder symptoms assessed across therapy		Danish Health Authority 2016
USA	FBT-BN		Motivational therapy ineffective in changing eating pathology			APA Practice Guideline 2012
Netherlands	FBT	CBT/CBT-E				Practice guideline for the treatment of eating disorders 2017
BINGE-EATING DISORDER						
UK		CBTgsh; CBT group				
Germany			Psychotherapy with parental involvement	Binge-eating episodes, abstinence from binge eating	Eating disorder psychopathology, depression, BMI	AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders
Avoidant/ restrictive food intake disorder						
Germany			Mealtime structure, cognitive-behavioral interventions with parental involvement	Eating disorder symptoms	Not specified	AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders
Netherlands			CBT for fear based problems, dietetic advice, speech therapy			Practice guideline for the treatment of eating disorders 2017
PICA						
Germany			Cognitive-behavioral interventions	Eating disorder symptoms	Not specified	AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders

Evidence-Based Psychological Therapies For Adults

COUNTRY	EVIDENCE-BASED RECOMMENDED FIRST-LINE THERAPY	EVIDENCE-BASED SECOND-LINE THERAPY	UNEVIDENCED ALTERNATIVE POSSIBILITIES, WEAK RECOMMENDATION, CLINICAL CONSENSUS	PRIMARY OUTCOME VARIABLES	SECONDARY OUTCOME VARIABLES	SOURCE OF EVIDENCE
ANOREXIA NERVOSA						
UK	CBT-ED; SSCM; MANTRA	Focal psycho-dynamic therapy		BMI, eating attitudes, body image, bulimic behaviors	Quality of life, anxiety, depression	NICE 2017
Germany	FPT; CBT-E; MANTRA; SSCM		Nutritional counseling, not as monotherapy	BMI		AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders
France			Supportive therapies; Psychodynamic therapies, or those related to psychoanalysis; CBT; Systemic and strategic therapies; Motivational approaches	Not specified	Not specified	HAS Clinical Practice Guidelines
Denmark		Individual or group psycho-therapy		Weight gain (using specific targets), eating disorder symptoms assessed across therapy	Additional focus on broader symptoms (unspecified), normalize BMI in the 20-25 range (21-26 for men)	Danish Health Authority 2016
Australia and New Zealand	CBT-ED; SSCM; MANTRA		Do not use CBTgsh or web-based therapies; Motivational enhancement therapy ineffective	Weight gain; biological normalization	Dietary change, enhanced body image, reduced compensatory behaviors	RANZCP guideline 2014
USA	None		Motivational therapy ineffective in changing eating pathology			APA Practice Guideline 2012
Netherlands	CBT / CBT-E individual or group; MANTRA; SSCM					Practice guideline for the treatment of eating disorders 2017
BULIMIA NERVOSA						
UK	CBTgsh; CBT-ED			Eating attitudes, body image, bulimic behaviors	Quality of life, anxiety, depression	NICE 2017
Germany	CBT (including DBT)	IPT	Psychodynamic therapy; CBTgsh	Abstinence from binge eating and compensatory behaviors, remission from bulimia nervosa, reduction of symptom severity	Eating pathology, depression	AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders

Evidence-Based Psychological Therapies for Adults (continued)

COUNTRY	EVIDENCE-BASED RECOMMENDED FIRST-LINE THERAPY	EVIDENCE-BASED SECOND-LINE THERAPY	UNEVIDENCED ALTERNATIVE POSSIBILITIES, WEAK RECOMMENDATION, CLINICAL CONSENSUS	PRIMARY OUTCOME VARIABLES	SECONDARY OUTCOME VARIABLES	SOURCE OF EVIDENCE
BULIMIA NERVOSA (continued)						
Denmark	CBT-BN	Individual or group psychotherapy	Do not use motivational enhancement therapy; consider adding physical exercise during weight gain phase	Eating disorder symptoms assessed across therapy		Danish Health Authority 2016
Australia and New Zealand	CBT-ED	CBTgsh	If no access to CBT-ED, then consider: IPT; DBT		RANZCP guideline 2014	
USA	CBT-ED	CBTgsh using structured manuals; IPT if CBT-ED is not effective	Motivational therapy ineffective in changing eating pathology			APA Practice Guideline 2012
Netherlands	CBT/CBT-E	IPT	DBT		Practice guideline for the treatment of eating disorders 2017	
BINGE-EATING DISORDER						
UK	CBTgsh; Group CBT-ED; individual; CBT-ED			Eating attitudes, bulimic behaviors	Quality of life, body image	NICE 2017
Germany	CBT (including DBT)	IPT	Psychodynamic Therapy; Humanistic Therapy; Behavioral Weight Loss Treatment in case of comorbid obesity; Combination of psychotherapy with or without Behavioral Weight Loss Treatment and with or without pharmacotherapy in case of insufficient monotherapeutic treatment	Binge-eating episodes; Abstinence from binge eating	Eating disorder	AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders
Australia and New Zealand	CBT-ED	CBTgsh	If no access to CBT-ED, then consider: IPT; DBT; mindfulness			RANZCP guideline 2014
USA	CBT-ED; Group CBT-ED	DBT; IPT				APA Practice Guideline 2012
Netherlands	CBT/CBT-E	IPT	DBT			Practice guideline for the treatment of eating disorders 2017

Evidence-Based Psychological Therapies for Adults (continued)

COUNTRY	EVIDENCE-BASED RECOMMENDED FIRST-LINE THERAPY	EVIDENCE-BASED SECOND-LINE THERAPY	UNEVIDENCED ALTERNATIVE POSSIBILITIES, WEAK RECOMMENDATION, CLINICAL CONSENSUS	PRIMARY OUTCOME VARIABLES	SECONDARY OUTCOME VARIABLES	SOURCE OF EVIDENCE
BINGE-EATING DISORDER (continued)						
UK			As per the nearest full diagnosis	BMI, eating attitudes, body image, bulimic behaviors	Quality of life, anxiety, depression	NICE 2017
Germany			As per the nearest full diagnosis	Eating disorder symptoms	Not specified	AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders
NIGHT EATING SYNDROME						
Germany			CBT; Progressive Muscle Relaxation	Eating disorder symptoms	Not specified	AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders
PURGING DISORDER						
Germany			As with bulimia nervosa	Eating disorder symptoms	Not specified	AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders
RUMINATION DISORDER						
Germany			EMG Biofeedback	Eating disorder symptoms	Not specified	AWMF German S3-Guideline Diagnosis and Therapy of Eating Disorders

Note:

AFT = Adolescent-Focused Therapy

CBT = Cognitive-behavioral Therapy

CBT-ED = Cognitive-Behavioral Therapy for Eating Disorders

CBTgsh = Guided Self-Help Cognitive-Behavioral Therapy

FBT = Family-Based Treatment

FPT = Focal Psychodynamic Therapy

IPT = Interpersonal Psychotherapy

MANTRA = Maudsley Model of Anorexia Nervosa Treatment for Adults

SSCM = Specialist Supportive Clinical Management

DBT = dialectical behavior therapy

BMI = body mass index

EMG = electromyography

For sources see "Guidelines used to create this document" in the "Training and Other Resources" section.

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About the Academy for Eating Disorders (AED)

The AED is a global multidisciplinary professional association committed to leadership in promoting EDs research, education, treatment, and prevention. The AED provides cutting-edge professional training and education, inspires new developments in the field of EDs, and is the international source for state-of-the-art information on EDs.

JOIN THE AED: Become a member of a global community dedicated to ED research, treatment, education, and prevention. Join online at www.aedweb.org.

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