

PRACTICE BRIEFS



Anorexia Nervosa

Contributors: Shannon L. Karl

ABSTRACT: Anorexia nervosa is a mental health disorder characterized by restriction of energy intake, significantly low body weight, intense fear of gaining weight or becoming fat, and emotional disturbance related to the way one's body weight or shape is experienced (American Psychiatric Association, 2022). Counselors play a critical role in prevention, early identification, interdisciplinary collaboration, family engagement, and provision of ongoing psychotherapy. Given ongoing concerns regarding under-identification of atypical presentations and culturally diverse manifestations of eating disorders, counselors are encouraged to use multiple assessment methods alongside clinical judgment and interdisciplinary consultation.

Introduction

Essential features of anorexia nervosa (AN) include restriction of energy intake relative to requirements, significantly low body weight, intense fear of gaining weight or becoming fat, and emotional disturbance related to the way one's body weight or shape is experienced (American Psychiatric Association [APA], 2022). Two subtypes of AN are recognized—restricting type and binge-eating/purging type—with severity categorized as mild, moderate, severe, or extreme based on BMI (APA, 2022, 2023). AN occurs predominantly among females and is more frequently found in post-industrialized countries with relatively high per capita income. Cultural, geographic, and social norms, as well as peer influences, should be considered during assessment and treatment planning.

Prevalence rates are highest among individuals identifying as non-Latinx White; limitations in existing research highlight the need for continued study with culturally and ethnically diverse populations (APA, 2022, 2023). Current annual prevalence estimates range from 0.4% to 0.9% among females, with lifetime prevalence estimates of up to 0.3% in males. Estimates of the female-to-male ratio of AN range from approximately 4:1 to 10:1 (APA, 2022; National Institute of Mental Health [NIMH], 2025).

Environmental and psychosocial risk factors include occupational or vocational activities that emphasize thinness, sociocultural pressures related to body ideals, socioeconomic conditions, and exposure to psychosocial stressors (Berg & Peterson, 2013; Berg et al., 2012; Gill et al., 2024; NIMH, 2025). Biological risk factors include female sex, family history of eating disorders, and developmental vulnerability during adolescence or early adulthood, with an average age of onset of approximately 19 years (APA, 2022; NIMH, 2024). AN carries one of the highest mortality rates among psychiatric disorders, with estimates of approximately 4% across the lifespan (APA, 2022, 2023; Crone et al., 2023; NIMH, 2025).

Assessment Strategies

There are well-established assessment instruments available to evaluate eating-disordered attitudes, behaviors, and symptom severity. Counselors play a critical role in prevention, early identification, interdisciplinary collaboration, family engagement, and provision of ongoing psychotherapy. Given ongoing concerns regarding under-identification of atypical presentations and culturally diverse manifestations of eating disorders, counselors are encouraged to use multiple assessment methods alongside clinical judgment and interdisciplinary consultation (APA, 2022; Bryant et al., 2022).

Accurate assessment further requires careful consideration of differential diagnoses, including avoidant/restrictive food intake disorder, bulimia nervosa, binge-eating disorder, body dysmorphic disorder, major depressive disorder, anxiety disorders, obsessive-compulsive disorder, trauma-related disorders, and medical conditions that may contribute to weight loss or appetite disturbance, as differential diagnosis is critical to informing appropriate treatment planning and level-of-care decisions (APA, 2022). The Eating Attitudes Test (EAT; Garner & Garfinkel, 1979; Garner et al., 1982) and the Eating Disorder Examination Interview (EDE; Cooper & Fairburn, 1987) represent two commonly used assessments. Specific information about the design, administration, and application of these instruments is provided below.

Eating Attitudes Test

The EAT (including both EAT-40 and EAT-26) is a widely used self-report screening instrument that has been applied to assess eating disorder risk in clinical and non-clinical populations (Garner & Garfinkel, 1979; Garner et al., 1982). The EAT is intended to assist mental health and educational professionals in determining whether referral for specialized evaluation is warranted. It does not provide a diagnosis but rather identifies behaviors that may be indicative of an eating disorder (Garner et al., 1982). The original 40-item assessment (Garner & Garfinkel, 1979) was developed primarily to assess AN symptomology. The updated and abbreviated 26-item assessment (Garner et al., 1982) improved efficiency and has broader applicability.

Items are rated on a six-point Likert-type scale regarding how often the subject engages in specific behaviors. The subjects may answer “always,” “usually,” “often,” “sometimes,” “rarely,” or “never,” with responses weighted to generate a referral index score (Garner et al., 1982). A total score of 20 or higher, or endorsement of specific high-risk items, indicate a need for further assessment. The EAT-26 and EAT-40 tests are copyrighted instruments; however, the copyright holders grant use permission at no cost.

Eating Disorder Examination Interview

The EDE is a semi-structured, clinician-administered assessment designed to evaluate eating disorder-specific psychopathology (Cooper & Fairburn, 1987). The accompanying Eating Disorder Examination-Questionnaire (EDE-Q) is a form-based self-report instrument that parallels the same structure as the original EDE. The EDE and EDE-Q assess four domains (restraint, eating concern, shape concern, and weight concern) and provide both subscale scores and a global score.

Forty-one responses are rated on a 0–6 scale reflecting behavioral frequency over the previous 28-day period. Point assessments from 1–5 are tallied for responses of “1–5 days,” “6–12 days,” “13–15 days,” “16–22 days,” and “23–27 days,” whereas scores of 0 or 6 correspond with zero and everyday occurrences, respectively (Cooper & Fairburn, 1987).

Scope of Practice

Counselors working with individuals affected by AN must practice within clearly defined professional boundaries while prioritizing client safety and interdisciplinary collaboration (American Counseling Association [ACA], 2014; APA, 2023).

Treatment Approaches

Achieving medical stability and maintaining a healthy weight range is of primary importance. AN disrupts multiple organ systems, making medical monitoring a central feature of treatment planning (APA, 2023; Crone et al., 2023). According to the NIMH (2025), treatment of AN involves key components:

- Restoration of a healthy weight and nutritional status.
- Psychological intervention addressing maladaptive thoughts and behaviors.
- Reduction of associated psychological sequelae.

During initial remediation of significant medical compromise caused by AN, inpatient treatment is often recommended to allow for continuous medical monitoring and supervised nutritional rehabilitation. This level of care supports stabilization of vital signs, correction of metabolic abnormalities, and safe weight restoration (APA, 2023; Crone et al., 2023). Although amenorrhea (the absence of menstrual periods) is no longer a diagnostic criterion for AN, its presence remains a clinically significant indicator of compromised physical health and endocrine dysfunction among individuals of reproductive age (APA, 2022; Berg & Peterson, 2013).

For individuals with AN who present with significant medical instability (e.g., bradycardia, hypotension, electrolyte derangements, or organ compromise), inpatient medical hospitalization is typically recommended early in treatment to ensure continuous physical monitoring and supervised nutritional rehabilitation prior to transition to lower levels of care. These medical indicators underscore the importance of counselor competence in recognizing serious risk and collaborating effectively within interdisciplinary treatment teams.

Consistent with the *ACA Code of Ethics* (2014), counselors have an ethical responsibility to practice within the boundaries of their competence, avoid harm, and seek appropriate consultation and collaboration when working with medically complex conditions such as AN. Accordingly, it is imperative that counselor education programs provide up-to-date knowledge and resources related to anorexia nervosa to support ethical and effective practice (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2024).

The etiology of AN is widely understood as multifactorial, reflecting the complex interaction of biological vulnerabilities (e.g., genetic predisposition, temperament traits such as perfectionism), psychological factors (e.g., a heightened need for control, difficulties with emotional regulation, and low self-worth), and sociocultural influences (e.g., societal pressures and weight stigma). Recognizing these intersecting pathways is critical for informing prevention efforts, as it highlights multiple points for early intervention. Community- and school-based programs can address these risk factors directly, while family-based prevention approaches may strengthen protective dynamics, including effective communication and the modeling of balanced eating behaviors. Collectively, these integrated strategies can reduce risk across diverse populations (APA, 2023; NIMH, 2025).

Family-Based Treatment

Family-based treatment (FBT), also referred to as the Maudsley approach, is an evidence-based long duration outpatient intervention for children and adolescents with AN (Haas et al., 2024; Le Grange et al., 2021). FBT emphasizes parental involvement in supervising nutritional intake and takes approximately one year to complete. Treatment is typically delivered in three phases: (a) weight restoration, (b) gradual return of eating control back to the adolescent, and (c) addressing developmental issues and termination. Given its demonstrated efficacy and sustainability, FBT is generally considered the first-line intervention for youth with AN (APA, 2023; Haas et al., 2024; Kress & Paylo, 2026).

Including family members in the therapeutic process is associated with improved treatment outcomes, particularly for children and adolescents with AN. Family-based and family-involved interventions address relational dynamics, support emotional regulation, and function as integral components of care

alongside medical and nutritional treatment (APA, 2023; Haas et al., 2024; Le Grange et al., 2021). Despite their demonstrated effectiveness, family-based approaches may be challenged by barriers such as parental consistency, time and resource demands, access to specialized services, and difficulties translating treatment strategies into daily routines, including family mealtimes (Datta et al., 2023).

Cognitive Behavior Interventions

Cognitive behavior therapy (CBT) addresses both the cognitive and behavioral components of AN, including distorted beliefs related to weight and shape, maladaptive schemas, and avoidance of food-related stimuli (NIMH, 2024). Individuals with AN frequently demonstrate cognitive rigidity and functional fixity, which may interfere with treatment engagement and flexibility in thinking. Cognitive remediation therapy (CRT) has been shown to improve cognitive flexibility and promote broader patterns of thinking and problem solving among individuals with AN (Kress & Paylo, 2026; Tchanturia et al., 2015; Thorsud et al., 2024). Exposure-based strategies, including exposure and response prevention, target the anxiety and negative affect commonly elicited by food exposure and may reduce avoidance while supporting more adaptive responses to eating-related stimuli (NIMH, 2024).

Cognitive behavior interventions, particularly when delivered within a strong therapeutic alliance, have also been associated with weight gain and symptom improvement in individuals with AN (Dalle Grave et al., 2022; Fairburn, 2008). Enhanced cognitive-behavioral therapy for eating disorders (CBT-E) is a transdiagnostic, evidence-based intervention typically delivered over approximately 20–40 sessions across four structured stages, depending on the individual's clinical presentation and weight status (Levinson et al., 2024). The initial stage focuses on engagement, psychoeducation, self-monitoring, and early behavioral change. A brief second stage involves review of progress and treatment planning. The third stage constitutes the core of treatment and emphasizes cognitive restructuring and behavioral experiments targeting eating disorder psychopathology. The final stage focuses on relapse prevention and consolidation of skills to support long-term recovery (Fairburn, 2008; Kress & Paylo, 2026).

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) has demonstrated utility in addressing emotion dysregulation, perfectionism, and comorbid anxiety, depressive, and personality-related features frequently observed in individuals with AN, particularly when delivered as an adjunctive intervention (Linardon et al., 2023). DBT emphasizes skill development in distress tolerance, emotion regulation, and behavioral change, which may support the generalization of adaptive eating behaviors and coping strategies into real-world contexts (NIMH, 2024).

Psychodynamic Approaches

For individuals who may benefit from more in-depth or longer-term intervention, psychodynamic approaches—including transference-focused and object relations therapies—are also considered valuable components of evidence-informed care for AN. These approaches are supported in the literature and emphasize the exploration of unconscious emotional and cognitive processes that contribute to the development and maintenance of the disorder (Osorio, 2025). They are especially well-suited for individuals who require longer-term, exploratory treatment, particularly when symptoms are chronic, complex, or intertwined with broader personality and relational dynamics. As such, they may complement more structured, short-term interventions by addressing deeper underlying processes that contribute to enduring vulnerability (Amianto et al., 2016; Osorio, 2025).

Cultural and Ethical Considerations

Cultural and ethical considerations are central to the assessment and treatment of AN, as sociocultural norms, identity factors, and systemic inequities influence symptom presentation, help-seeking behavior, and access to care. Although AN has historically been associated with White, female, and higher-income

populations, emerging research highlights limitations in existing prevalence data and the risk of under-identification among culturally, ethnically, and gender-diverse individuals (APA, 2022; Sonne et al., 2024). Counselors must therefore approach assessment with cultural humility, recognizing that body ideals, eating practices, parenting styles, family roles, and expressions of distress vary across cultural contexts and may not align with dominant diagnostic assumptions.

Use of culturally responsive, multimethod assessment strategies, and clinical judgment is essential to reduce bias and avoid misdiagnosis or delayed intervention (Bryant et al., 2022). Ethically, counselors have a responsibility to practice within the boundaries of their competence, prioritize client welfare, and engage in interdisciplinary collaboration when working with medically complex conditions such as AN (ACA, 2014). Given the disorder's significant medical risk, counselors must remain vigilant in recognizing indicators of medical instability and seek consultation, referral, or higher levels of care when warranted (APA, 2023).

Family involvement, although often critical to effective treatment—particularly for children and adolescents—must be navigated with sensitivity to cultural values, caregiver burden, and systemic barriers to care (Billman Miller et al., 2024). Consistent with accreditation standards, counselor education programs play a vital role in preparing practitioners to integrate cultural responsiveness, ethical decision-making, and evidence-based practice when working with individuals and families affected by AN (CACREP, 2024).

Advocacy

Consistent with the counseling profession's ethical commitment to client welfare, social justice, and equitable access to care, counselors are ethically obligated to advocate for individuals affected by AN. The *ACA Code of Ethics* (2014) emphasizes the responsibility to promote client well-being and avoid harm (A.1.a; A.4.a), address barriers and systemic inequities that impede access to services (A.7.a), and engage in advocacy efforts that support the dignity and needs of vulnerable populations (Advocacy Introduction; A.6.a). Accordingly, counselors are encouraged to advocate at individual, institutional, and policy levels for timely access to evidence-based, interdisciplinary, and culturally responsive treatment for AN, particularly for historically under-identified and underserved populations.

Conclusion

AN remains one of the most medically and psychologically complex mental health disorders, requiring timely recognition, coordinated interdisciplinary care, and the application of evidence-based interventions. Effective treatment prioritizes medical stabilization and nutritional rehabilitation while addressing the cognitive, emotional, and relational processes that maintain the disorder (APA, 2023; Crone et al., 2023). Given the serious medical sequelae and elevated risk associated with AN, counselors play a critical role in prevention, early identification, ongoing risk assessment, and collaboration with medical and nutritional professionals. Consistent with ethical obligations and accreditation standards, counselor education programs must ensure that trainees are equipped with current knowledge, skills, and resources to recognize medical compromise, engage families appropriately, and support evidence-based care (American Counseling Association [ACA], 2014; CACREP, 2024).

Resources

General Information

- [Academy for Eating Disorders](#)
- [Anorexia nervosa](#), Mayo Clinic
- [Anorexia nervosa](#), National Eating Disorders Association
- [Eating disorders](#), National Institute of Mental Health

For Counselors

- [Clinical Guidelines on Eating Disorders: A Practical Tool for Trainees and Clinicians Alike](#), APA
- [Beck Institute for Cognitive Behavior Therapy](#)
- [CBT Treatment Article](#), NCBI
- [EDE-Q](#), McGill University
- [Cultural Formulation Interview](#), APA

For Clients and Family

- [National Institute of Mental Health](#)
- [National Eating Disorders Association](#)
- [National Association of Anorexia Nervosa and Associated Disorders](#)

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