Understanding eating disorders and disordered eating

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EATING DISORDERS AND DISORDERED EATING TRAINING FOR SCHOOLS

Setting the scene

Eating disorders (EDs) and disordered eating

- Definitions
- Prevalence
- Who is affected?
- Causes
- Treatments
- Challenges

Eating disorders (EDs)

Eating disorder = a persisting disturbance of eating that impairs psychosocial functioning and health

- Scope of talk
  - Most common eating disorders
  - Disordered eating

Outside the scope of this talk

- Less common eating disorders / conditions

- Avoidant Restrictive Feeding Intake disorder (ARFID) –Dr Amy Lovell's presentation

Eating Disorders

Anorexia Nervosa

Restriction of Energy intake

- significantly low body weight (wt)/ less than minimally expected wt

Intense fear of weight gain / fatness

- behaviour that interferes with wt gain, despite low wt

Disturbance in body image

- self-evaluation unduly influenced by body wt/ shape
- persistent lack of recognition of seriousness of low wt

Bulimia Nervosa

- Recurrent binge-eating
- Inappropriate compensatory weight control behaviours → Frequency ≥ 1 / week for 3mths
- Self-evaluation unduly influenced by body weight / shape

Binge Eating Disorder

- Recurrent Binge-eating
- Abnormal eating behaviour with marked distress / guilt
- → Frequency ≥ 1 / week for 3 months

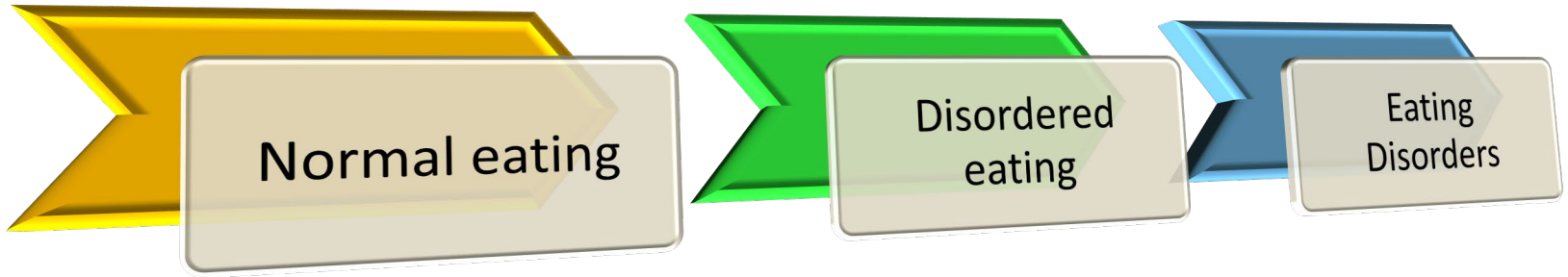
Other Specified Feeding & Eating Disorders - OSFED

Mixed behaviours / presentation, but serious illness:

- Atypical AN (AAN) – 'normal' weight AN
- Sub-threshold BN
- Sub-threshold BED
- Purging Disorder
- Night Eating Syndrome

Diagnostic instability / crossover

Disordered eating



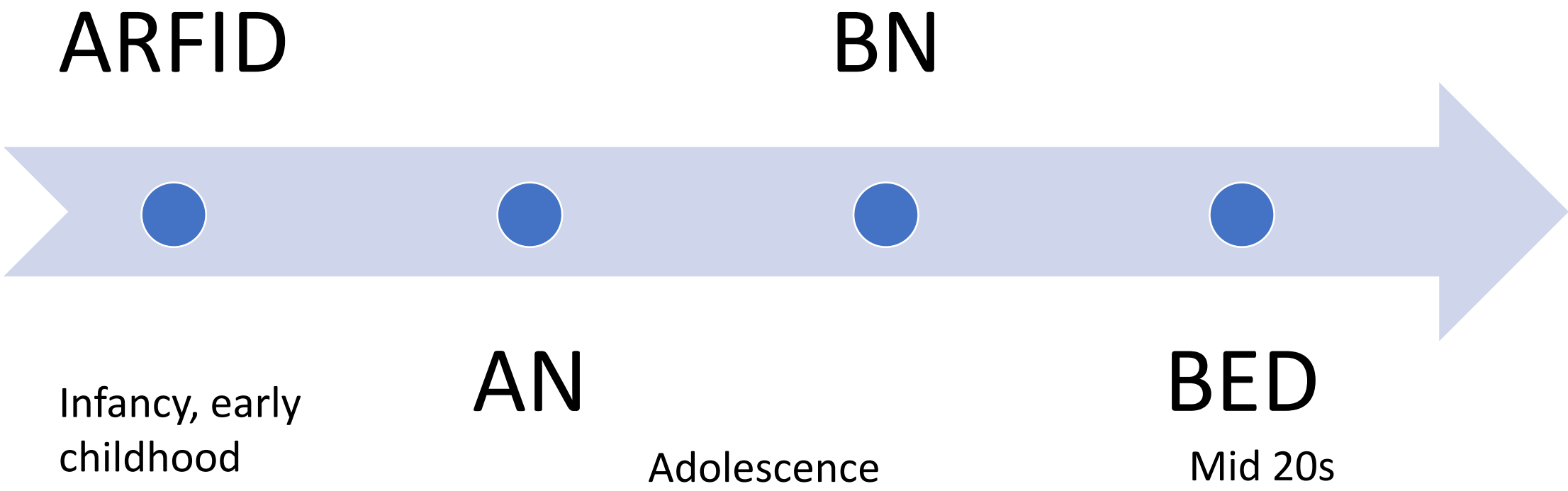
Include unhealthy eating and weight control behaviors

- e.g. chronic or yo-yo dieting, binges, vomiting, fasting, skipping meals, compulsive eating, excessive exercise

But, lower frequency / intensity and not **(yet)** clinically significant

- May spontaneously recover, be stable, or may be a step on the way to an ED
- Driven by the same psychological factors as EDs

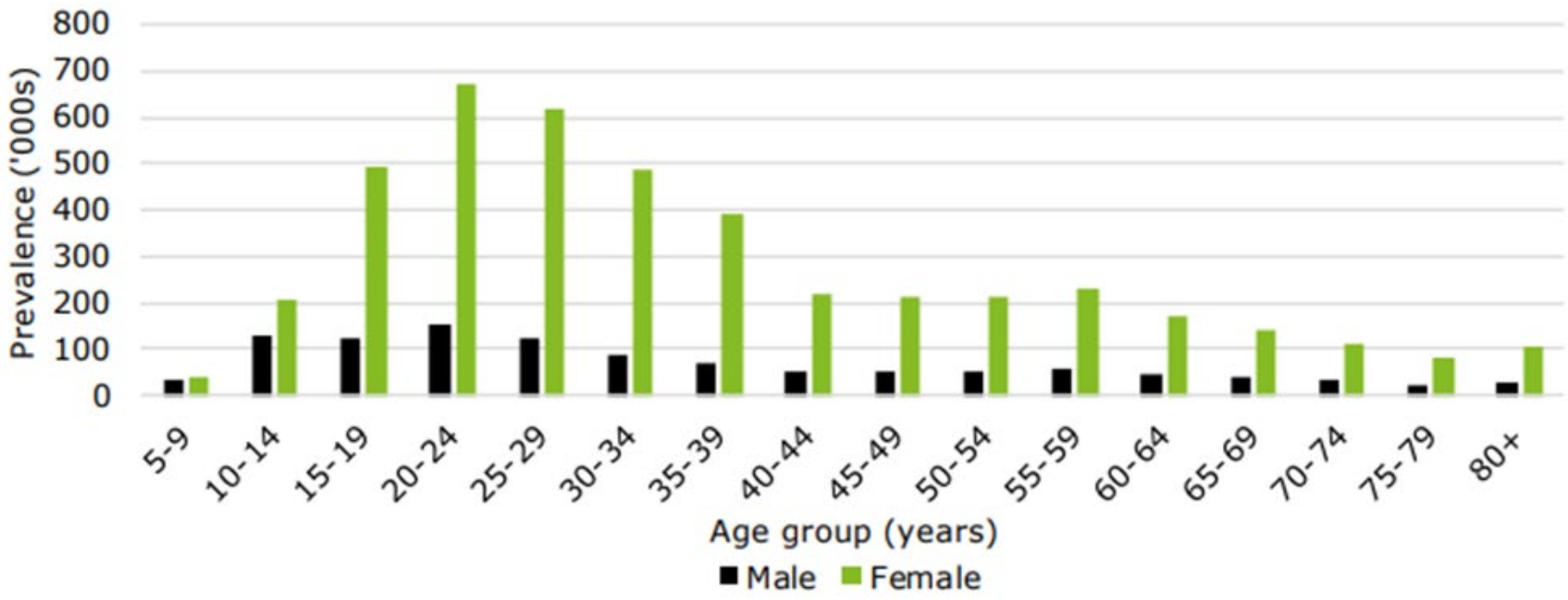
Typical ages of onset



What does it look like over the life span? The

STRIPED study 2020 p iv

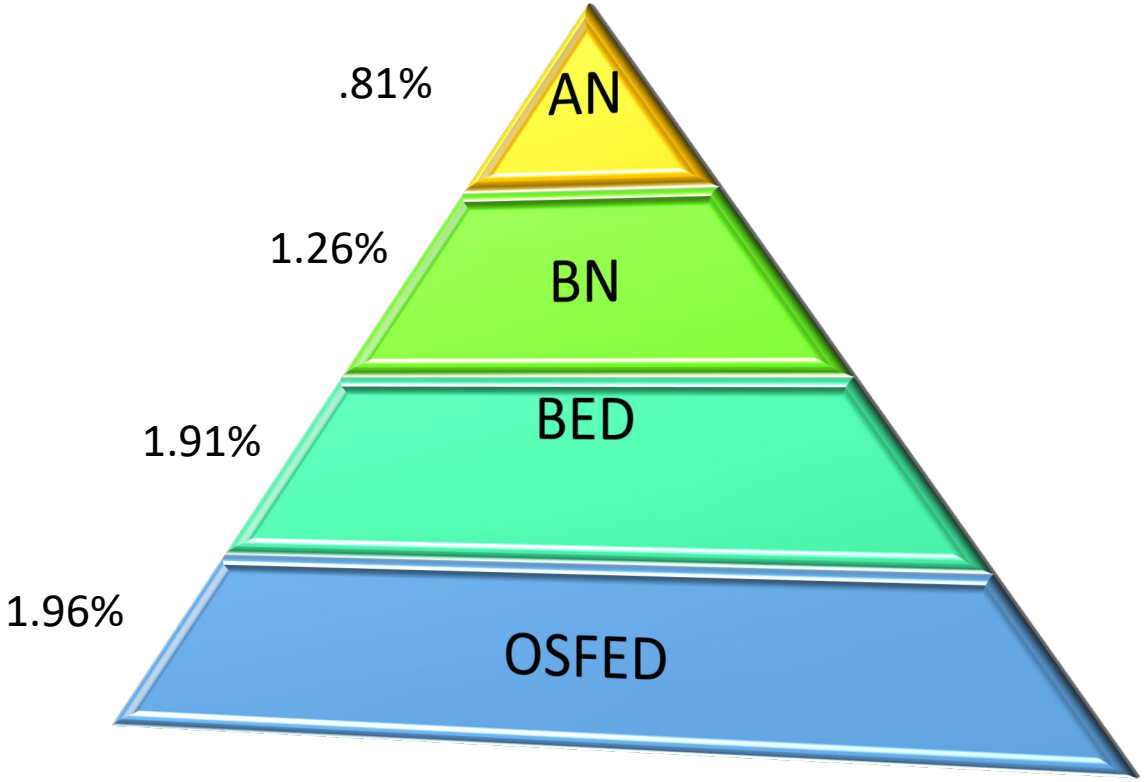
Chart i: One-year prevalence of EDs in the US in 2018-19



- Over 80% of eating disorders develop before adulthood (Garland et al, 2019)
- Lags in treatment journey
- Mean duration is 10 years (Allison et al, 2021)

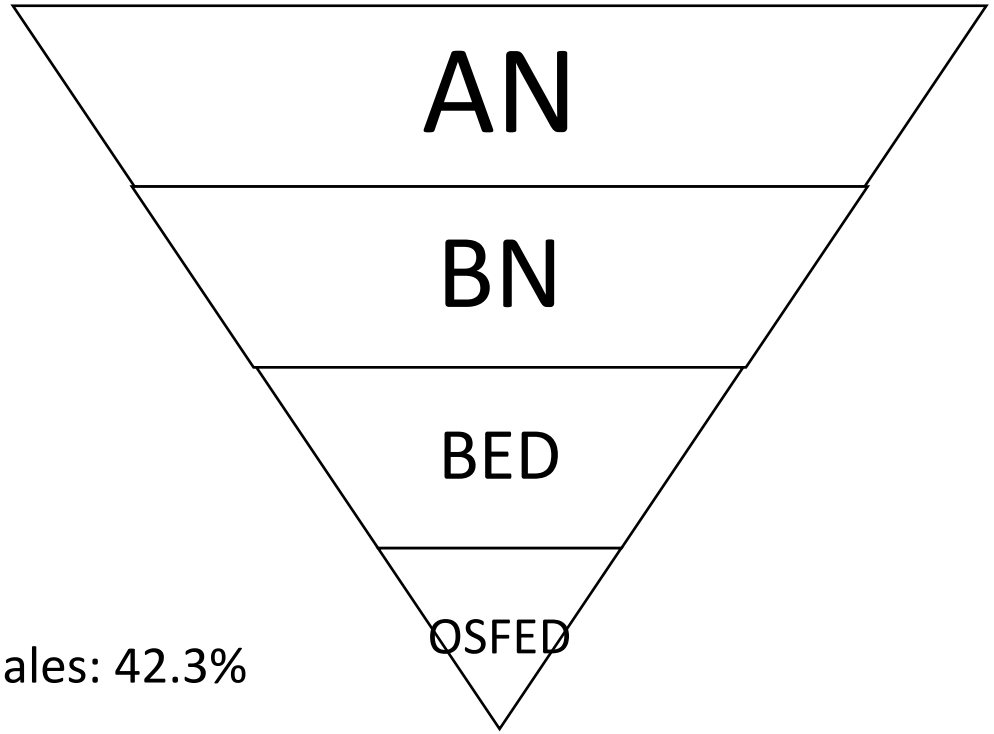
The prevalence of EDS

Galmiche et al (2019)



Proportion receiving treatment

Only 20% present for treatment



- **Youth'12** – Tried to lose weight last 12m-Females: 68.6% Males: 42.3%
- Disordered eating is on the rise

Who gets an ED?

Michaela Pettie- EDGI project

Who gets an ED?

- Despite the stereotype → not just young Caucasian Cis females
- EDs in most ethnic minorities are at least as high as in epidemiology studies, including in NZ
- Māori with EDs are under treated in NZ (Lacey et al, 2020)
- Little research so far on specific treatment needs

➢See presentation by Christine McKercher & Brittani Beavis

Males with EDs

- Previous estimates 1:10 male to female ratio
- Recent studies, prevalence is closer to 1:4

- Most therapies are developed for females
  - males often excluded in research trials

- Males report feeling uncomfortable in female-focused treatment settings

- Lack of consensus on whether to
  - Adapt mainstream treatments?
  - Develop of male-specific treatments?

Barriers to getting help

- Stigma (self and others)
- Under-recognised
- Under-treated

LGBTQI +

- Elevated rates of EDs and DE in this community
  - Up to 18% lifetime prevalence
  - Disordered eating rates are even higher

  (Coelho et al., 2019) Hartman-Munick et al (2021)

- Body image issues particularly marked/ distressing in young trans people

- ED behaviours may be used to modify body shape

➢More training and resources needed for clinicians and professionals in this area

Barriers to getting help

- Stigma (self and others)
- Under-recognised
- Under-treated

Co-occurring problems

- Up to 70% of those with EDs have comorbid conditions

  - Depression, bipolar disorder – increased risk of self-harm
  - Anxiety disorders: generalised anxiety, social anxiety; OCD, trauma
  - Substance use
  - Personality traits and disorders
  - Autism spectrum disorder (esp. in AN)

Physical problems e.g.

  - Type 1 diabetes
  - Gastrointestinal disorders e.g. Coeliac's and Crohn's disease

Why do people get eating disorders?

EDs are multifactorial

Childhood/ family	Societal	Personal	
Genetics Pre-existing metabolic risks (lipids, insulin, activity levels) (ANGI) Family build Family attitudes toward eating/ weight etc Family stress / conflict Trauma	Gender role stereotypes "ideal body" Social media (See Gemma Sharp presentation)	Obsessionality / cognitive inflexibility Perfectionism/ self-criticism Difficulty regulating emotions Low self-esteem Low mood, anxiety Early puberty Higher pre-morbid weight Body dissatisfaction Gender/ sexual identity Physical illness Life stressors	Disordered eating or eating disorders

Other broader societal contextual factors

- Toxic food environment (Brownell, 2004)
  - Impact of the Western diet on metabolism (Ayton & Ibrahim, 2020)
- Reduction in activity levels
- Shift in BMI for population
  - Obesity epidemic panic and stigma
- Persistence of unhealthy body image ideals

See Sylvia Pyatt and Tarsh Green presentation

Other situations that may increase risk

- COVID – upsurge in referrals in Waikato (Hansen et al, 2021)
- Sports
  - Certain body type / size
    - Emphasis on weight and nutrition - weight power ratio
    - Weight classes e.g. rowing
  - Relative Energy Deficiency in Sports (RED-S)
    - food intake is insufficient for exercise level
    - affects males and females
  - Certain look
    - Ballet, gymnastics
  - Body revealing uniforms/ sports gear
    - Swimming, gymnastics, beach volleyball

For more about what to look out for, see Heidi Brace and Genevieve Mora presentation

Treatments for eating disorders

Disordered eating

- use treatment for the condition it most resembles

The New Zealand ED treatment context

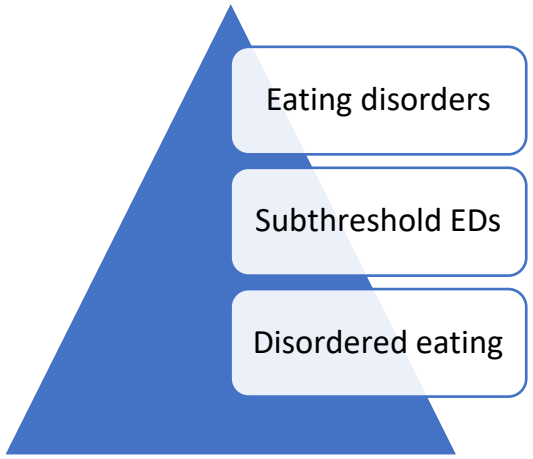
Stepped care approach

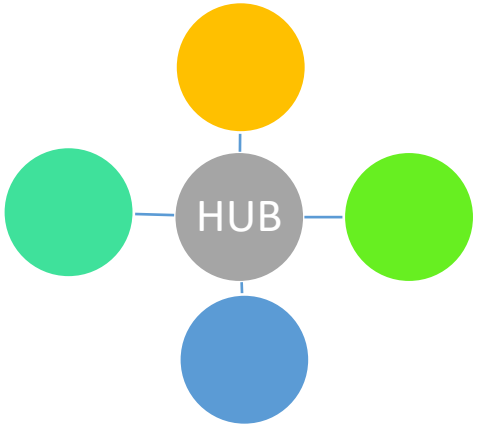
Specialist Eating Disorders Services

Hub and spoke model

- 4 specialist ED hubs across NZ
  - Three hubs provide residential or inpatient facilities
  - Assessment + treatment
  - Consultation, supervision and training from a multidisciplinary team
- Eating disorder liaison clinicians

To learn more about referral pathways and for other questions,
Regional service and EDL clinicians breakout rooms at 3pm





What kinds of therapy are used in specialist services?

Treatments for EDs in young people

AN

Family Based Therapy (FBT)

- **Variants of family involvement**

Individual therapies

- **Cognitive behaviour therapy variants (CBT-T, CBT-E)**
- **Specialist supportive clinical management (SSCM)**
- Maudsley Anorexia nervosa treatment for adults (MANTRA)
  - Cognitive remediation
- Adolescent-focussed therapy
- Focused psychodynamic psychotherapy
- Treatment as usual

BN

- **Family Based Therapy (FBT)**

Individual therapies

- **CBT**
- Guided self help (CBT)
- Dialectical Behaviour therapy
- Interpersonal psychotherapy

BED / Binge spectrum

- Less well researched in young people
- **FBT**

Individual therapies

- **Guided self help**
- **CBT**
- Group therapy
- Interpersonal psychotherapy

  - Dialectical Behaviour therapy,
  - Acceptance and Commitment Therapy
  - Mindfulness
  - Dissonance based group

Outcomes of current therapies

Most people benefit from treatment

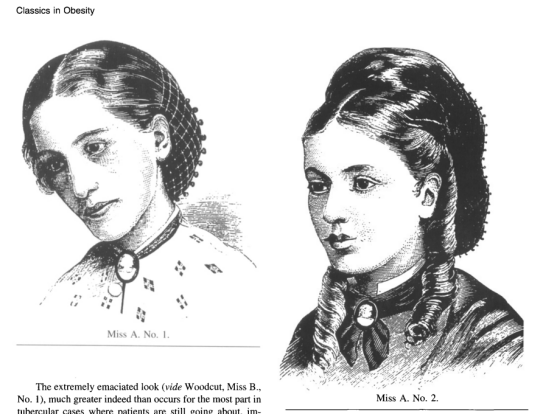
- Better outcomes for adolescents and children than adults (FBT)
- Recovery
  - Recovery takes time - a process vs. an endpoint
  - Recovery rates – 25% recovered, 50% improved, 25% with little response (Treasure et al 2020)
  - BED and BN – higher recovery rates post treatment 40-60%

  - Early referral has best chance of recovery, but…
    longer duration is not an impediment (Radunz et al (2020))
- Long term follow-up studies found recovery continues over time
  - USA – 22 years - AN 62.8% BN 68.2% recovered (Eddy et al 2017)

  - Sweden –30 years, 64% with AN were fully recovered (Dobrescu, et al, 2020)

- NZ treatment trial outcomes are comparable with international studies e.g. McIntosh et al, (2016)

Challenges with current treatments



Anorexia Nervosa

The core treatment for AN is little changed since Gull (1873) prescribed nourishing food and nursing care

- The treatment now is ….food and weight restoration, with psychotherapeutic support

- Still no medications especially for AN
- Still few options for those with AN for whom our current treatments are of limited benefit
- Unmet needs for family support (Fletcher et al, 2021)

Challenges with current treatments

- Current therapies have different theories and strategies but achieve similar outcomes
  - Little information to guide treatment selection
    - Need better information re who does well with what treatment?
    - What are the effective elements of therapy?
    - What modifications are necessary for minority groups?
    - Incorporating patient choice- those affected want holistic therapy (beyond symptom focus)

- Need to keep looking for potential tools outside the psychotherapeutic box
  - Genetics research may help with
    - Risk prediction … which may help with targeted prevention
    - Biological pathways implicated in specific symptoms so we can develop novel drug targets

KAUPAPA OHA KOHUKI KAI
EDGI
EATING DISORDERS GENETICS INITIATIVE

Challenges for service provision in NZ

- Increase in prevalence of disordered eating, as well as increased distress in young people
- Increased demand for services, exacerbated by COVID
  - Access issues
- Under recognition and treatment of males, ethnic and gender diverse
- Current treatments although effective, don’t help everyone

All the above are issues reported internationally

Summary

- Disordered eating and subthreshold EDs are common in young people
- EDs are serious and complex conditions
  - Look beyond the stereotypes
    - Don’t overlook symptoms in males, gender diverse + ethnic minorities
    - Don’t reassure that it will pass
  - Be aware of the risks posed by some sports / activities
- Current treatments help most people

Where to from here?

- **Prevention** programmes in schools to build mental health resilience
- **Increasing treatment capacity** in the community in improve access
- Improving current treatments
  - Addressing needs of under-treated groups
  - Enabling patient preferences
  - More support for whānau
- More research needed re developing innovative treatments beyond the current paradigms

Final thoughts

Reference sheet available with slides