Eating Disorders
Are we doing enough?

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25 June 2013
Myth 1

Anorexia nervosa is the most serious eating disorder
Isabelle Caro
1982-2010
Fact 1

All eating disorders are serious

- **Crude mortality rates**
  - 4.0% for anorexia nervosa (AN)
  - 3.9% for bulimia nervosa (BN)
  - 5.2% for the residual category, now referred to as “other specified feeding or eating disorder”

- All-cause and suicide standardized mortality ratios significantly elevated for all disorders (Crow et al., 2009)

- AN and BN are the 6th and 8th greatest cause of disease burden in 15-24 year old Australian women
Physical QoL

Wade et al., 2012
Mental QoL

Wade et al., 2012

Flinders University
Myth 2

Eating disorders are all about dieting
Make a supreme effort to root out self-love from your heart and to plant in its place this holy self-hatred. This is the royal road by which we turn our backs on mediocrity, and which leads us without fail to the summit of perfection.

Saint Catherine of Sienna (1347-1380)
Fact 2

Eating disorders are a means to an end

• Providing a **sense of identity and achievement** to a person who feels that they are of little worth or have little to offer the world as a person in their own right

• Increasing a **sense of control** when a person feels that they have few skills to cope with navigating through the complexities that life brings

• Helping to **distance or distract** a person from strong, uncomfortable emotion
Myth 3

Eating disorders are only common in adolescent girls
In adolescent girls

• Across three times of assessment, 699 girls aged 12 to 19

• 58 (8.3%) reported a lifetime eating disorder

Wade, unpublished data
Fact 3

Eating disorders are common in people of all ages

• 10% of people with an eating disorder are male

• 23% of 9,688 women aged 22-27 years (mean age 25) had disordered eating Wade et al., 2012

• 35 first-year undergraduate students volunteered for a study asking for healthy young women with no eating problems: 8 (23%) had to be excluded for the presence of a disordered eating within the last month
Myth 4

Eating disorders are caused by families
Risk factors over the life span

- Female gender
- Genetics
- Birth
- Gastrointestinal problems
  - abuse/neglect (father)
- Escape avoidance coping
  - Low social support
  - Perfectionism
  - Negative Affect
  - Ineffectiveness
- Weight concerns, dieting

- Difficulties with emotional regulation

<table>
<thead>
<tr>
<th>5 years</th>
<th>10 years</th>
<th>15 years</th>
<th>20 years</th>
<th>25 years</th>
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Environmental challenges in order of contribution

- Media internalization
- Pressure to be thin
- Peer teasing about weight
- Low levels of parental care
- Adverse life events

Wade et al., 2013
Fact 4

Many different risk factors work together to cause an eating disorders

Including Gene Environment interactions and correlations
Treatment in SA over 5 years

Ben-Tovim et al., 2001
Principles of effective interventions

• Inpatient treatment is insufficient for recovery
  • 30-50% of patients relapse within one-year of discharge from hospital
• We need at least 20-40 sessions of specialist evidence-based outpatient treatment to help people recover
  • 66% of adults with a BMI > 17.5 can recover after 20 sessions and 78% of children and adolescents with a BMI < 17.5 have partial to full remission from AN at 12-month follow-up
• nutritional counselling & fluoxetine not indicated
What intervention is indicated when BMI > 17.5?

- Cognitive Behavioural Therapy – Enhanced (CBT-E)
  Fairburn 2008
  - Four phases over 20 sessions, 5 months
  - Phase 1: self-monitoring of eating and weekly weighing, Psycho-education, Establishing regular eating
  - Phase 2: collaborative case formulation
Fig. 2. A schematic representation of the extended cognitive behavioural theory of the maintenance of bulimia nervosa. 'Life' is shorthand for interpersonal life.
What intervention is indicated when BMI > 17.5?

• Cognitive Behavioural Therapy – Enhanced (CBT-E)  
  Fairburn 2008
  • Four phases over 20 sessions, 5 months
  • Phase 3: focus on maintaining mechanisms, eliminate dietary restraint, body checking
  • Phase 4: relapse prevention
Do we have other options?

- Guided self help (CBT)
- Interpersonal psychotherapy
- Diáletical behaviour therapy
- Antidepressants
- For younger adolescents:
  - No difference between CBT Guided Self Care and Family Based Therapy at 12-month follow-up but CBT offered a more rapid reduction of bingeing, lower cost, and greater acceptability for adolescents Schmidt et al, 2006
What intervention is indicated when BMI ≤ 17.5?

- For adolescents, family based therapy (FBT): 78% of children and adolescents have partial to full remission at 12-month follow-up
  - Meta-analysis end of treatment data indicated that FBT was not significantly different from individual treatment but superior at 6- and 12-month follow-up *Couturier et al., 2012*
- Adolescent CBT-E showing promise *Dalle-Grave et al, 2013*
  - At 60-week follow-up 77% of people entered into the study achieved good outcome for psychopathology but only 28% weight restored
What about treating adult AN?

Current treatment trial across Perth, Adelaide and Sydney Byrne, Wade et al.,

Comparing three treatments:

CBT-E Fairburn 2008
MANTRA Wade et al., 2011
Supportive specialist care McIntosh et al., 2005

Strong without anorexia nervosa
The role of significant others

FROM
pernicious influences
(Charcot, 1850)

TO
Partners in treatment
- support
- skills training
## Statewide eating disorder service

<table>
<thead>
<tr>
<th>Day program</th>
<th>The Hub</th>
<th>Bed Based Services</th>
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<tbody>
<tr>
<td>&gt;15 years</td>
<td>Consult-liaison services across all age groups</td>
<td>Management of complex care requiring intensive follow-up</td>
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<tr>
<td>Group based work supervised meals</td>
<td>Dedicated family based therapy for children and adolescents</td>
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<tr>
<td>Around 6 weeks duration</td>
<td></td>
<td></td>
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<tr>
<td>Step up-step down</td>
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**Spoke services: outpatient**
**What about prevention?**

<table>
<thead>
<tr>
<th>For Younger Adolescents</th>
<th>For Older Adolescents and Young Women who have body image concerns</th>
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<tr>
<td>Media Smart</td>
<td>Student Bodies</td>
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<tr>
<td><em>media literacy</em></td>
<td><em>psycho-education and CBT</em></td>
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<td>Wilksch &amp; Wade, 2009</td>
<td>Taylor et al 2006</td>
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<td>The Body Project</td>
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<td><em>cognitive dissonance</em></td>
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<td>Stice et al 2006</td>
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Where does SA need to head from here?

• Prevention needs systematic dissemination and evaluation including health impacts
• Eating disorders have been under-resourced, we should be working towards a reputation of excellence in the prevention and treatment of eating disorders
• Greater availability of evidence based treatments – mental health workers need to feel more comfortable dealing with eating disorders
• We need to provide more support to carers – they are a valuable resource and a partner in treatment
Questions?