Therapy for life-threatening eating disorders works, so why can't people access it?

May 8 2017, by Richard Newton

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Eating disorders are complex mental illnesses that have one of the highest death rates of any psychiatric disorder. Among people with anorexia nervosa – who commonly deprive themselves of food due to an obsessive fear of gaining weight – this rate is more than five times greater than in the general population.

All eating disorders are associated with significant, wide-ranging physical health complications such as starvation, cardiac arrest (sudden loss of heart function), kidney problems, food intolerance and fits. These are among the leading causes of hospitalisation for mental-health-related issues in Australia.

Because serious medical complications so frequently accompany eating disorders, they defy classification solely as mental illnesses. They should be viewed as complex health-care issues requiring urgent and multidisciplinary care.

Yet many health-care providers have not been provided with enough basic education and training to be able to recognise and respond appropriately to someone presenting with an eating disorder. So despite their severity, eating disorders often go unrecognised.

This leads to substantial economic costs for the Australian health system and devastating effects for sufferers, loved ones and the communities that surround them.

What are eating disorders?

Eating disorders have been around through recorded history. Even an ancient Egyptian tomb painting depicts a noble self-inducing vomiting.

There are several types of eating disorders. These include anorexia nervosa, bulimia nervosa and binge eating disorder. Collectively, these are characterised by abnormal eating behaviours, poor body image, overemphasis on weight and shape, and extreme weight-control behaviours.

In the case of anorexia, such behaviours lead to severe weight loss and often life-threatening complications. Vomiting, laxative abuse and

excessive exercise can be features of both anorexia and bulimia, as can binging and purging.

Unlike the severe weight loss associated with anorexia, bulimia is characterised by the presence of binging and usually purging at a relatively normal weight. Binge eating disorder features frequent binging, in the absence of purging or other compensatory behaviours, which often leads to significant weight gain.

Eating disorders are also commonly accompanied by low self-esteem, guilt and disgust, along with depression, severe anxiety and suicide risk.

Who gets eating disorders?

There are psychological, environmental and biological (including genetic) risk factors for developing eating disorders. A genetic predisposition in combination with poor body image is one of the strongest predictors of disordered eating.

Poor body image has been reported in nearly half of Australian women and over one-third of Australian men Disturbingly, the rate of body-image concerns is even greater in children and adolescents. A study of Australian children found up to 61% of girls and boys between the ages of eight and 11 are trying to control their weight.

Around 10% of the Australian population will experience an eating disorder in their lifetime, and the rate is increasing. For example, one study observed a two-fold increase in disordered eating between 1995 and 2005 in South Australia. And a more recent study in the same state observed a more than two-fold increase in extreme dieting and binge eating between 1998 and 2008.

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While the reasons for this increase have not yet been fully explored, they may be related to increasing concerns about weight in the general Australian population.

Contrary to the long-held belief eating disorders are the domain of wealthy young females, the greatest increase has been observed in older people, males and those in lower socio-demographic groups.

This may be due, at least in part, to inadequate access to treatment, differences in people seeking treatment, or detection in under-represented groups, and stigma surrounding the development of a disorder commonly associated with a specific (different) group in the community.

How are they treated?

A number of evidence-based treatments are available for eating disorders. It is important to note that no single approach will be effective for all individuals.

People who are unable to access effective treatment early experience greater duration and severity of illness. They then need more complex, prolonged treatment.

Structured, psychological therapies are considered the cornerstone of treatment for eating disorders. For adolescents with anorexia, this takes the form of family-based therapy. This involves helping the whole family support the person with the disorder.

In adults with eating disorders, evidence shows a minimum of 20 sessions of cognitive behaviour therapy (CBT) – which challenges learnt ways of thinking – is necessary. In severe cases of anorexia, at least 40 CBT sessions that include a strong emphasis on restoring healthy eating attitudes and behaviours are required.

A multidisciplinary team is best equipped to address the complex nutritional, medical and psychological needs of someone with anorexia.

Increasing funding to improve outcomes

The total social and economic costs of eating disorders in Australia exceed A$69 billion per year. These costs can be reduced with early detection.

Most people with eating disorders go a long time before receiving adequate care. One study of over 10,000 adolescents found that, while

nearly 90% of those with an eating disorder contacted a service provider for help, in only a minority (3-28%) of cases were the services specifically for their eating disorder.

Factors such as denial, shame, stigma and a lack of recognition of eating disorder symptoms by health-care professionals are likely contributors to this discrepancy.

Medicare provides Australians with funding for ten sessions with an allied mental-health professional (such as a psychologist or social worker). This is below the minimum treatment recommendation of 20 sessions for all eating disorders.

We should not accept a system that prevents people with a severe life-threatening mental illness from accessing a treatment that is available, effective and will save costs in the long term.

Federal Health Minister Greg Hunt recently requested the Medicare Benefits Schedule Review Taskforce investigate increasing Medicare coverage to treat people with an eating disorder. We urgently need early identification of eating disorders and the delivery of quality, targeted treatments at evidence-supported durations.

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